FINAL REPORT

of the

ASSEMBLY HEALTH CARE INVESTIGATING INTERIM COMMITTEE

HOUSE RESOLUTION No. 295

JULY 1, 1946

COMMITTEE MEMBERS

ERNEST R. GEDDES, *Chairman*

Sam L. Collins
James G. Crichton
Ernest E. Debs
John W. Evans
Fred H. Kraft
Vincent Thomas

CALIFORNIA LEGISLATURE

Hon. Charles W. Lyon
Speaker of the Assembly

Hon. Thomas A. Maloney
Speaker Pro Tempore of the Assembly

Arthur A. Ohnimus
Chief Clerk of the Assembly

California. Legislature. Assembly. Health Care Investigating Interim Committee

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STAFF

Virgil M. Griffin, *Actuary*
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LETTER OF TRANSMITTAL

HONORABLE CHARLES W. LYON,
Speaker of the Assembly
California State Legislature
Sacramento, California

MR. SPEAKER: The Assembly Health Care Investigating Interim Committee, appointed by you pursuant to House Resolution No. 295 (Regular Session 1945), submits herewith to you and through you to the Governor, the Legislature and to the people of California this report of your committee.

Cut off at an early date because of the peculiar provision in the resolution which requires us to report back on or before July 1, 1946, this report is filed as of this date with the Chief Clerk of the Assembly since the Legislature is not in session.

The major portions of this report have been prepared in mimeographed form as a Preliminary Report dated June 26, 1946, for more immediate distribution to the Governor, the members of the Legislature and interested persons and an order placed with the State Printer to print 1,000 copies of this report for general distribution to the public.

According to our understanding of the somewhat unusual technicalities which confront us in filing a report when the Legislature is in adjournment the printing is in the nature of a "pre-print" of a portion of the complete and final report which the next session or an extraordinary session may order printed and which may, if it is the will of the Legislature, include the many pages of testimony gathered by this committee in its hearings.

Recommendations of the committee are made in the body of this report and individual recommendations of several members. However, it is our unanimous recommendation that the present committee be reconstituted at the beginning of the next regular session and that hearings be held on the factual matter in this report. In the ensuing six months much may be brought to light to supplement the data herein contained.

What is set forth here is the result of study, hard work and dispassionate analysis and we believe that many of the questions in the minds of the Legislators are answered or, at least, the members of the Legislature will now have valid information upon which to determine their future course of action.

Respectfully submitted.

ERNEST R. GEDDES, Chairman

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REPORT OF THE ASSEMBLY HEALTH CARE INVESTIGATING INTERIM COMMITTEE, H. R. No. 295 *

INTRODUCTION

During the fifty-sixth session of the Legislature a number of hearings were held to consider Assembly Bills Nos. 449 and 800 and other bills pertaining to the subject of a State operated plan of prepaid medical care.

However, most of the debate and public interest centered around Assembly Bill No. 449 and Assembly Bill No. 800 both of which provided for a State operated plan financed by compulsory contributions from persons engaged in employment covered by unemployment insurance provisions generally.

The chief point of difference in the two proposed pieces of Legislation was that under Assembly Bill No. 449 the physicians would be paid on a capitation basis while under Assembly Bill No. 800 the physician would be paid on a "fee for service" basis.

Both of these bills failed to become law although proponents of one would have probably accepted the other as a compromise to establish a system of prepaid medical service in California. But all the members of the Assembly were not satisfied that complete and valid answers had been given to many of the most important questions relating to the subject.

Accordingly House Resolution No. 295 was adopted creating the present committee to study the subject at greater length and in greater detail and report back not later than July 1, 1946.

The membership of the committee was not appointed for some weeks following the close of the session and so has been faced with the task of rendering a comprehensive report in a shorter period of time than is generally allotted interim committees.

A study of the text of the Resolution, which is printed in full in the appendix of this report will show that the committee is charged with reporting on a number of subjects all relating to the general subject of means for maintaining and improving the health of the people of the State of California.

Early in its history the members of the committee agreed that the sociological and political arguments already presented before it were but repetitions of arguments for and against compulsory sickness insurance which have been presented many times in many places and by many authorities in the past.

It was also agreed that if a substantial service is to be rendered to the members of the Legislature no great good would obtain from hearings before which repetitious speeches were made but little valid factual information presented.

Accordingly it was determined to make an approach differing materially from those made previously and engage principally in an actuarial

* For text of the Resolution see page 151.

survey of all data obtainable in order to determine; first, the incidence of illness which may be expected to obtain among large groups of the population and; secondly, to endeavor to make a valid estimate of possible costs of rendering medical and hospital service.

Because of their intimate connection most of the other subjects set forth in the Resolution are touched upon and considered in the discussion attending the principal subjects as stated above.

Probably the chief exponent of Prepaid Medical Care is Dr. Nathan Sinai who was witness for the proponents of the proposed Legislation lately before us. In going over some the material left by Dr. Sinai in Sacramento seeming discrepancies were noted and the chairman wrote him as follows:

April 24, 1946

Dr. Nathan Sinai, Professor of Public Health
University of Michigan, Ann Arbor, Michigan

DEAR DR. SINAI: As you are aware this Committee is engaged in making a survey of the various aspects of Health Care of the people of California. In so doing we are endeavoring to ascertain and compile statistical and factual information from all available sources. In the course of your testimony and other work in this State you supplied the office of the Governor with certain estimates in connection with the incidence and costs of medical care. The source of much of that material is stated in the text but there were some other points concerning which we should be very much interested in determining the authority or statistical basis. Should you be able to furnish us with this, your action in doing so will be much appreciated. It will undoubtedly be of great assistance to this committee in the furtherance of its purposes.

Much of the material mentioned above is in the form of letters and transcripts of telephone conversations. We have reviewed them and have, for your convenience in referring to the estimates in question, noted down enough of the leading data to give you an idea of what kind of information we require.

The enclosed list, therefore, is not sent to you in the nature of a questionnaire but rather as memos signifying what we have in mind. In addition to this, any other source material you may like to suggest to us will receive our earnest attention.

With reference to "Estimates Costs of Services under A.B. 800"

(a) Administrative assumed 6%—How arrived at?
(b) Hospital based on Blue Cross—The experience of which Blue Cross Plans were included and for what year?
(c) X-ray and Laboratory—On what is this figure of $2.00 per person per year based?
(d) Physician Service of $15.20—is this basis on National Average?—if so for what year? Is it not based on the amount actually paid to physicians and surgeons?

Re: Letter of April 3, 1945
Sub: Fiscal Aspects of Assembly Bill 800

(a) "Basic Factors": estimates there will be 22,181,200 services (defined as office and home calls, hospital service, X-rays, and other services and treatments—Study of Dr. Nathan Sinai), per member per year for 4,720,000 eligibles. This is less than 2 services per eligible per year. On what factual data is it based?

To File — Sub. beg. 1945
From W.T.S. — Date 5-7-45

(a) States that Dr. Sinai estimates Hospital for surgical cases only would cost $6.00 per person while previous estimates estimated cost of Hospitalization for all causes at $6.56. What are the sources of the estimate that hospitalization for sickness would be about $.56 per person per year?
(b) What are sources of estimate that surgical and obstetrical costs would be, average, $6.50 per person?

Paper headed — Dr. Sinai 5-8-45
re: A.B. 2201

(a) States surgical cost $7.00
X-ray and Lab. $2.50
On what assumptions are these estimates based?
(b) Part "3" of following page states inclusion of "anaesthetics, drugs, medicine"—What is the estimated cost of these, and where included in the estimated total of $17.30?

(c) Part "5" indicates "pre-natal services to maternity cases." Costs? Where included in $17.30?
(d) "Comments by phone"—(4) "Care during and following childbirth"—What is estimated cost and where included in $17.30?
(e) Under "Financial Comment" estimate of hospitalization raised to $7.56, would this affect previous estimates under A.B. 800?

We are indebted to the cooperation of Mr. Sweigert of Governor Warren's office who extended every courtesy to Mr. Virgil M. Griffin, our Actuary, and since these estimates have a direct bearing on those arrived at through our own efforts we are most anxious to have the information requested and thank you sincerely.

Very truly yours,
(Signed)

ERNEST R. GEDDES

To this letter Dr. Sinai replied:

UNIVERSITY OF MICHIGAN SCHOOL OF PUBLIC HEALTH
ANN ARBOR, MICHIGAN, May 2, 1946

Mr. Ernest R. Geddes, Chairman
Assembly Health Care Investigating Interim Committee
1445 Alameda Street, Pomona, California.

DEAR MR. GEDDES: I have your letter relating to the basic data used in arriving at estimates of services and administrative costs under the legislative proposals submitted last year. I note with pleasure that the Committee has employed an actuary to serve on its technical staff.

In arriving at the estimates a number of sources were utilized, including some unpublished studies of experience in the operation of voluntary plans. The studies included those of the Committee on the Costs of Medical Care, the Blue Cross experience, certain of the earlier studies made in California, our data from the State of Washington, data from the Social Security Board and the United States Public Health Service, our research program in Ontario, Canada, and some information from other reported experience. The chief task was to take the existing information and adjust it to the conditions that might obtain in California if an organized system of prepayment were developed.

In arriving at estimates of costs one of the chief elements, too often given little attention, is the type of organization and administration under which a system is expected to operate. Of necessity certain assumptions must be made concerning the way a system is to work because these have a distinct bearing on the costs. The assumptions involve the form of physicians, for formula of payment to hospitals, the "paperwork," the process of controls and other factors. In other words, one starts with the concept of organization and administration and works toward the costs. Too often the reverse of this procedure is followed—with some disastrous results.

Since you are approaching the problem with a fresh start and with the services of a technical staff, may I suggest that much would be gained by independent investigation. In this way it would be possible for your Committee to resolve, in its own mind, the enormously differing estimates that were presented to the Assembly in 1945. While my own time is limited, I would be glad to make accessible to a member of your staff our files of information and have him discuss with members of my staff the administrative procedures and their influence on the subjects mentioned in your letter.

Sincerely yours,
(Signed)

NATHAN SINAI

Thus it is seen that at least one authority in the field agrees with this committee that the subject of costs has not generally received the attention it deserves.

In order to conduct its researches the committee engaged Mr. Virgil M. Griffin an actuary of wide experience with commercial insurance companies and lately engaged by a highly respected firm of consulting actuaries on the Pacific Coast.

This work is lengthy, since there is much to discuss. However, not all of the material gathered by the committee is printed but is filed according to provisions of the joint rules with the Legislative Auditor for further use and reference of the Legislature if desired.

It is idle to presume that the subject of prepaid medical care will not again be brought before the Legislature and if such is the case the principal arguments as to need and desirability will again be advanced. Therefore, little of those arguments appear here.

While a majority of the people of this State are against Compulsory Sickness Insurance a substantial majority nevertheless favor a State operated plan in competition to the voluntary plans now in operation. This is borne out by a Survey of Public Opinion conducted for the committee by California Associates in which a representative sample was taken in areas blanketing the entire State. The complete report appears as a Section of this report.

The majority and minority recommendations of the committee are in the final Section of this report together with the observations of individual members.

Only those who have attempted research on the general subject of Health Care know the vast amount of material on hand on the library shelves and in the document files. Much of it is old and most of the newer writings refer to the previous works and in many cases the advocates fail to give complete quotations. However, this committee through its staff, has not hesitated to search this material for any tables or statements which are felt to be of value.

Two publications which are matters of record, having been presented before the former legislative committee and reintroduced before the present committee, are the Argument in Support of Assembly Bill No. 449 by the State C.I.O. Council, Research Department and the work "Financial Aspect of Health Insurance" by Samuel C. May, Bureau of Public Administration, University of California. Both of these refer to major works previously published and where such works are quoted reference is made to the original work rather than the second.

Some evaluation is made of the argument found in already published works but for the most part such publications are listed in the bibliography for the information of those interested.

The members of this committee well knowing the heavy demands on the time of the legislator suffer no delusion that all will read this report in its entirety. Subsequent sections of this report substantiate the statements made in the next section which is a summary of the entire report.

SECTION ONE

SUMMARY OF THE FINDINGS OF THE COMMITTEE

1. Sickness strikes among the rich and the poor, rural dwellers and urban dwellers, in California in much the same pattern of frequency as in the rest of the Nation.

2. The insurance carriers and the voluntary plans have demonstrated that by the insurance plan of spreading the risk the cost may be averaged and protection afforded at equitable rates to the insured.

3. There is general satisfaction with insurance and voluntary plans among the subscribers.

4. Many who want Sickness Insurance can not obtain it because of the group provisions.

5. Few in the moderate income groups can afford complete coverage for all members of the family at average premium rates.

6. High rates result in adverse selection against the insurer.

7. Compulsory insurance eliminates lapsations on the part of those who have collected benefits, thus requiring post benefit contributions as well as prebenefit contributions.

8. Compulsory Sickness Insurance can not be provided for three per cent of payroll unless:

   (a) Physicians operate on a salary, capitation or reduced fee basis, or

   (b) Medical Care is rendered through group practice with facilities provided by the State, and

   (c) Hospitals are supported or regulated by the State or new methods of hospitalization as relating to operative and non-operative cases are adopted, or

   (d) Indigent sick are still cared for as at present.

9. Facilities in this State are below the level which must obtain if the people are to have adequate care.

10. The State can and should provide facilities so that no person goes without medical care who needs it.

11. The State Department of Health should be given the duty and power to collect data pertaining to the health of the people, the availability of medical care and its effectiveness.

12. Full actuarial studies should be initiated and maintained to measure the incidence of illness among employed persons in the State eligible to collect benefits under the recent Unemployment Compensation Disability Benefits Act, Chapter 81, 1946.

13. Commercial Insurance companies have no propriatary interest in the health of the people.

14. The medical fraternity operates out of its proper sphere when it engages in insurance practice but the non-profit motive if adhered to and the expansion of the service entitled it to license as a means of making medical care more widely available.

15. There is great need for better health education among all the people.

16. While the costs of medical care may be averaged as among persons comprising a group the equalization of costs through proportionate amount of income results in increased total costs to groups in the higher income levels.

17. The argument that Compulsory Sickness Insurance is an exercise of the Police Power of the State is falacious unless the police power be extended to regulate the individual not only in the matters of sanitation and quarantine but to the point of forcing attendance upon the physician and compliance with the physician's orders, thus making the physician an enforcement officer with full powers over the individual in all matters pertaining to the individual's health.

SECTION TWO

HEALTH OF THE PEOPLE OF THE STATE OF CALIFORNIA

A measurement of the health of the people of this State presupposes; first of all, some unit by which measurement may be made and; secondly, some reportorial device by which all of the departures from normal health may be arranged for comparison and observation. But neither of these exist and the means of surveying a population presently estimated to number more than nine millions of persons are not available to this committee.

Locked in the records of our hospitals and of the practitioners of the healing arts are more or less complete data concerning most of the persons who sought, and obtained, medical treatment. In the records of the various Bureaus of the State Department of Health we have accessible the records of births and deaths, of the number of persons afflicted with communicable diseases and of those affected by epidemics and the daily census of governmental institutions reflects the thousands of persons confined therein for treatment of mental disorders, as well as the diseases and illnesses peculiar to the aged and the sicknesses and accidents which strike among the indigent.

But there are thousands of persons who do not receive the service of the physician either because of inability to secure such services or an unwillingness to do so.

There are thousands of others who in time will add to the case load because today through poverty, ignorance or indifference they are not receiving proper care, shelter or nourishment and thousands of children who will not long survive because of lack of attention which might be afforded them at birth and in the first few years of life.

On the other hand there are thousands of people living because, through the application of medical knowledge by the practitioner and the activities of the State Department of Health, vaccinations, innoculations and immunizations have stamped out, almost to the vanishing point, those diseases which formerly took such deadly toll.

In another section of this report recommendations are made for expansion of the activities of the State Department of Health by which, through the cooperation of the medical fraternity, insurance firms and other interested parties, more accurate measures may be made of that portion of the population requiring medical attention in each locality and in various groups classified as to age, occupation, race and economic status.

There have been numerous previously undertaken projects dealing with the subject of prepaid medical care and the amounts spent by individuals and families for medical care and hospitalization during the periods surveyed. Many works on the subject, however, are frankly arguments in support of either National or State plans to provide medical care by means of compulsory insurance methods.

It is to be expected, and is, indeed the case, that most of these works incorporate, at least by reference, the findings and tabulations of earlier surveys which were made with the expenditure of considerable time and money.

The California C.I.O. Council, Research Department, in its presentation and exhibits in support of Assembly Bill No. 449 during the fifty-sixth session of the Legislature quotes from various of these authorities and has filed with the present committee a copy of the work through its research director Mr. Paul Pinsky.(1)*

As in the C.I.O. presentation many of the authorities quoted are frankly attacking the question from the social viewpoint and stress the lack of medical care obtained or possible to be obtained by families in the lower income groups.

One of the most frequently quoted of the major project reports is that entitled—Medical Care for the American People, Final Report of the Committee on the Costs of Medical Care. (2)

This volume although furnishing a tabulation showing Medical Services Needed and Received per 1,000 individuals classified according to Families With Specified Income gives no estimate of the morbidity rate or incidence of illness. But this work does state on page 5—"In a nation wide survey of illness and costs of medical service among 9,000 white families, the committee found that there was substantially the same incidence per family or per individual in the various broad income groups." A footnote to the foregoing quotation adds, however, the following, "The incidence of recognized and recorded illnesses in the Committee's study was lowest in the low income groups and highest in the groups with highest income. It is not known to what extent the higher rate in the upper income classes is due to economic and social factor. Data from the U. S. Public Health Service and other sources indicate that when the groups with incomes under $1,500 or $2,000 are further subdivided, a definite relation appears between poverty and illness, the lower income groups having more illness and illness of longer duration."

This last contention seems borne out by most of the other statistical matter which has come to the attention of this committee. The State C.I.O. Council in its presentation quotes the publications—Health Insurance for California, Report of the Social Security and Man-power, and Research Departments, California State Chamber of Commerce (3) which in turn quotes the following figures for California taken from the State Relief Administration Study of 1935 showing the rates of disabling sickness by income for 1933.

Annual Income Class	*Disabling Illnesses Per 1,000 Persons in Families in 3-Month Period*	*Year**
Relief	180	720
0- $599	137	558
$600-1,199	127	508
1,200-1,999	123	492
2,000-2,999	128	512
3,000-Over	116	464
All Incomes		542

* Yearly incidence estimated at 4 times the three-month figure.

We also show below a tabulation made by Margaret C. Klem, State Relief Administration—"Medical Care and Costs in California Families in Relation to Economic Status, 1937" (Page 174) (5) which we have

* Figures refer to works listed in bibliography.

converted to a per 1,000 person basis to make it comparable to the foregoing table.

Annual Income Class	*Persons Per Thousand Reporting Illness*
Relief	658
0- $599	681
$600-1,199	668
1,200-1,999	641
2,000-2,999	607
3,000-Over	600
	642*

* Our estimate of over all incidence.

The discrepancy between the over all figures of 542 and 642 respectively may be because of the fact that the illnesses reported in the first survey were classed as disabling or that the second figure shows the results of a wider and more comprehensive survey.

However, the former figure seems valid according to a statement on Page 99 of the work of Klem in collaboration with I. S. Falk and Nathan Sinai: "The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Family Groups, 1933," (6) which states—"Considered by income, the percentage of persons reporting *no illness* does not depart significantly from the average of 47 per cent except for the persons in families with incomes of $5,000 and more."

If 47 per cent report *no illness* then 53 per cent or 530 per thousand individuals may be inferred to have reported illness.

The various tables in the report of the Senate Committee to Investigate the High Costs of Medical Care, (7) income divisions, are on a difference basis but we may use the overall figure obtained during a three months survey, multiply by four to convert to a yearly basis and express as persons per thousand reporting illness or needing medical attention.

It should be remembered that the survey made by the Senate Committee covered large groups and included all of the members of all of the families surveyed. The significant figures follow:

Source	*Persons Needing Medical Care Per 1,000 Individuals*
Appendix D. Table II	544
Appendix D. Table III	552

All of the foregoing figures show that if the surveys made were indicative of the experience of the entire population of the State from 500 to 650 individuals in every thousand suffered from illness during the years 1933-1934 and 1935.

Coming now to more recent experience collected by the present committee in analysis of the claim records of various insurance companies and prepaid plans none the less significant because they relate to illnesses occurring to persons insured against the costs for medical care arising out of the illness reported.

Reference is made to the complete tables which appear in this work in the section devoted to the report of the actuary. For purposes of making

ready comparison we give the incidence of illness per 1,000 individuals and name the table from which the information is derived.

Actuarial Report Page	*Table*	*Experience*	*Incidence Per 1,000 Insured Individuals*
17	14	C.P.S. (Med. Rider—2 Visits Deduct.)	413
17	15	C.P.S. (Med. Contract—Males)	456
17	15	C.P.S. (Med. Contract—Females)	645
18	16	C.P.S. (Med. Contract—All Members)	580
25	24	H.S.S. of S.F. (All Members)	637

In addition to the above figures and those presented in the foregoing pages it should not be lost sight of that under insured plans there is an incidence of from 120 to 190 cases requiring hospitalization per 1,000 individuals.

In none of the surveys has much attention been paid to that unfortunate segent of our population confined in the various governmental institutions and hospitals for the tubercular, and mentally afflicted.

In the tables immediately following this section will be found the estimated number of persons cared for largely at public expense. Those exclude veteran facilities which are a responsibility of this State and the Federal Government by which provision is made for our sons and daughters whose service to their country entitles them not only to everlasting gratitude but to the best in medical and rehabilitation services that can be afforded.

Those factors affecting availability of medical service which should be discussed as affecting the different groups of our population are treated in a subsequent portion of this report.

BEDS AND AVERAGE DAILY LOAD IN VARIOUS GOVERNMENTAL HOSPITALS*

Name of Hospital	*Ownership*	*Beds*	*Average Daily Census*
Agnew State	State	3,725	3,663
Ahwahnee Tri-County T.B	Co.	101	90
Riverside County	Co.	355	190
Wish-i-ah Sanitarium	City	100	90
Placer County	Co.	136	92
Kern County General	Co.	575	533
Ernest Cowell Memorial	City & Co.	100	43
Camarillo State	State	4,500	3,900
Colusa County Memorial	Co.	32	26
Imperial County Farm	Co.	91	85
Sonoma State Home	State	3,492	3,325
Humboldt County Sanitarium	Co.	55	35
Humboldt County Isolation	Co.	16	6
Solano County General	Co.	110	95
Fowler Municipal	City	10	7
San Joaquin General	Co.	640	394
Fresno County General	Co.	550	409
Kings County General	Co.	225	141
Los Amigos County	Co.	2,844	2,391
Hoopa Valley Indian	U. S.	29	25
Napa State	State	3,960	3,900
Stony Brood Retreat	Co.	102	99
Lindsay Municipal	City	23	20
Arroyo Del Valle Sanitarium	Co.	276	211
Los Angeles County General	Co.	3,394	2,621
Los Angeles Co. Jail Hosp.	Co.	64	54
Los Angeles Juvenile Hall	Co.	121	97
Los Angeles Receiving	City	29	24
Madera County	Co.	130	75
Contra Costa County	Co.	216	155
Yuba County	Co.	87	61
Merced General	Co.	245	183
Stanislaus County	Co.	250	187
Brete Harte Sanitarium	Co.	159	110
Nevada County	Co.	100	82
Newell Community	U. S.	210	141
Norwalk State	State	2,465	2,344
Highland—Alameda County	Co.	485	271
Olive View Sanitarium	Co.	1,045	1,000
Orange County	Co.	369	254
Palo Alto	Co.	163	150
Patton State Hospital	State	3,826	3,745
El Dorado County	Co.	60	46
Plumas County	Co.	44	35
Tehama County	Co.	56	48
Shasta County	Co.	54	54
Canyon Sanitarium	Co.	87	65
Hassler Health Home	City	275	200
Olson Prison	State	136	51
Sacramento County	Co.	475	325
Monterey County	Co.	230	162
San Bernardino County Char.	Co.	324	247
San Diego County General	Co.	762	508
Laguna Honda Home	City & Co.	900	775
Langley Porter Clinic	State	100	30
San Francisco Hospital	Co.	1,366	964
University of California	State	279	243
Soboba Indian	U. S.	34	20
Santa Clara County Hospital	Co.	421	344
Santa Clara County Sanitarium	Co.	104	100
Fairmont Hospital of Alameda Co.	Co.	750	725
San Luis Obispo General	Co.	80	42
San Luis Obispo T.B. Sanitarium	Co.	44	22
Community Hospital of San Mateo	Co.	201	101
Neumiller Hospital (San Quentin)	State	203	130
Marin County Hospital	Co.	99	45
Santa Barbara General	Co.	275	182
Santa Cruz County	Co.	163	132

* Data taken from American Hospital Directory 1945, published by American Hospital Association.

BEDS AND AVERAGE DAILY LOAD IN VARIOUS GOVERNMENTAL HOSPITALS—Continued *

Name of Hospital	*Ownership*	*Beds*	*Average Daily Census*
Sonoma County	Co.	416	336
Tuolumne County	Co.	41	28
Pacific Colony	State	1,821	1,528
Tulare-Kings Counties Joint T.B.	Co.	108	107
Stockton State	State	5,679	4,732
Mendocino State	State	3,081	2,904
Tulare County General	Co.	193	44
Vallejo Community	Co.	261	50
Ventura County	Co.	328	206
Visalia Municipal	City	50	30
Weimar Joint Sanitarium	Co.	550	484
Lewis Memorial	U. S.	12	3
Siskiyou County	Co.	155	109
Sutter County	Co.	45	26
Total		55,577	47,507

* Data taken from American Hospital Directory 1945, published by American Hospital Association.

NOTE: The significance of the daily census (i.e. average beds occupied) is that based on estimated population of 9,000,000 persons, 5.28 out of every thousand persons were each day confined in some sort of an institution provided by City, County, State or Federal Government.

In other words there were 17,340,055 bed days or almost 2 for every man, woman and child of the State.

At an average assumed cost of $4.00 per day for each patient per day the cost would be $69,360,220.00 or a yearly per capita cost of $7.71 for this type of care alone.

SECTION THREE

ADEQUACY OF EXISTING SOURCES TO MAINTAIN AND IMPROVE THE HEALTH OF THE PEOPLE

It may be broadly stated that in many areas facilities exist for health care but to certain of the people they are not available because of economic barriers. In other areas sufficient wealth exists but facilities are lacking.

Included with the report of the Actuary are tables showing distribution of hospital beds and physicians in respect to population.

There is now and there has been an acute shortage of beds in California's non-governmental hospitals.

It may be catagorically stated here that if Assembly Bills 449 or 800 had been enacted at the fifty-sixth session of the legislature and the people entitled today to hospitalization because of payment of contributions qualifying them to enter the hospitals the normal incidence of demand would result in a shortage of 18,000 beds.

Now this shortage of hospital beds exists regardless of whether charges for their use are prepaid or not and the chief reason it is not brought more forcibly to our attention is that the governmental hospitals take on the indigent load while the least pressing cases continue to get along without operations and hospital treatment.

Doctors are returning to California practice since the termination of their service in the Armed Forces and there are a number who came to this State during the war. They are with few exceptions exceedingly busy because most of the population is financially able at present to afford their services—but a shortage exists, particularly in those sections outside our metropolitan areas. The table printed below shows the count of members of the professions classified under the healing arts as their names are listed in the current Telephone Directories for 1945-1946 in California.

Such listing, where the practitioner is exposed to being sought out by prospective patients is a better indicator than the professional directories which contain the names of many licensed to practice but not in the field of ordinary availability to the public.

COUNT OF PRACTITIONERS OF HEALING ARTS AS LISTED IN TELEPHONE DIRECTORIES OF VARIOUS AREAS

DIRECTORY	Chiropracters	Dentists	Opticians	Optometrists	Physicians & Surgeons. D.O.	Physicians & Surgeons. M.D.
Alhambra	39	66	2	20	35	90
Barstow	–	1	–	–	–	7*
Calaveras	6	20	–	9	3	28
Canoga Park	52	49	1	14	33	93
Coachella Valley	–	–	–	–	1	7*
Colton	8	5	–	3	4	14
Colusa County	1	4	–	–	–	6
Compton	19	19	–	5	13	24
Contra Costa County	29	56	3	12	4	73
Corona	4	3	–	1	–	6
Covina	9	11	1	2	2	19
Crescent City	2	8	–	3	–	7
Culver City	5	8	–	4	4	15
Downey	10	9	–	4	5	24

* Not otherwise stated.

COUNT OF PRACTITIONERS OF HEALING ARTS AS LISTED IN TELEPHONE DIRECTORIES OF VARIOUS AREAS—Continued

DIRECTORY	Chiro-practers	Dent-ists	Optic-ians	Optom-etrists	Physicians & Surgeons. D.O.	Physicians & Surgeons. M.D.
Elsinore	4	4	-	2	2	8
Fowler	-	1	-	1	-	2
Fresno	30	62	2	25	17	84
Gilroy	3	2	-	-	-	4
Glendale	62	113	2	25	58	168
Glenn	6	8	-	2	1	14
Humboldt	7	19	3	4	2	22
Huntington Beach	1	2	-	1	1	3
Imperial County	6	7	-	4	3	19
Inglewood	23	30	-	6	15	56
Kern County	20	32	-	11	17	63
Laguna Beach	1	7	-	2	4	7
Lake Tahoe	-	1	-	-	-	10*
Lancaster	2	1	-	1	3	1
Lassen	2	8	-	2	-	10
Lindsay	1	1	-	-	1	4
Lodi	7	10	-	6	3	16
Lompoc	1	2	-	-	-	3
Long Beach	78	133	6	35	73	336
Los Angeles	599	1,209	32	333	603	2,264
Los Gatos	2	5	-	1	-	5
Manteca	-	1	-	-	-	2
Marin County	9	32	3	5	5	37
Midway District	4	3	-	1	1	7
Modesto	14	22	1	13	3	42
Monrovia	6	5	-	2	8	17
Montebello	3	3	-	1	3	10
Monterey	9	32	2	9	10	53
Napa County	17	45	3	10	4	71
Needles	1	-	-	-	-	2
Newhall	2	1	-	-	1	3
Oakland	138	425	21	83	38	583
Ontario	8	11	-	4	5	19
Orange County	42	55	4	20	26	96
Oxnard	1	6	-	1	4	6
Palm Springs	8	3	1	2	2	17
Palo Alto	2	31	1	5	7	38
Pasadena	20	40	11	27	60	207
Pomona	13	26	-	8	10	41
Redlands	5	8	1	3	2	19
Reedley	1	3	-	1	-	5
Riverside	14	24	2	5	16	40
Sacramento	36	90	10	28	15	115
San Bernardino	24	32	4	12	5	47
San Diego	57	140	34	20	41	267
San Fernando	3	8	-	2	3	12
San Francisco	19	742	32	116	37	1,003
San Jose	44	55	3	21	7	98
San Luis Obispo	6	14	2	6	5	21
San Mateo County	16	58	2	9	4	67
San Pedro	20	27	-	8	5	53
Sanger	-	1	-	2	-	5
Santa Barbara	10	28	3	7	2	62
Santa Clara County	6	22	2	10	2	18
Santa Cruz County	11	23	-	6	7	35
Santa Maria	3	5	-	3	1	11
Santa Monica	25	70	3	15	17	102
Santa Paula	2	2	-	2	3	5
Shasta	8	13	-	6	4	23
Sierra Madre	2	3	-	1	2	5
Sonoma	21	47	-	11	10	66
South Bay Area	8	16	-	5	0	22
Stockton	20	42	-	16	11	56
Ventura County	8	5	-	5	9	28
Whittier	9	17	-	4	10	25
Total	1,722	4,152	198	1,053	1,328	6,973

* Not otherwise stated.

It is stated by Klem that the following pattern of illnesses recurs among the entire population of the United States.

In a Group of 1,000,000 Persons 470,000 each year will suffer no recognized illness.

320,000	will be sick once	320,000 illnesses
140,000	will be sick twice	280,000 illnesses
50,000	will be sick three times	150,000 illnesses
20,000	will be sick four or more times	80,000 illnesses
530,000	persons will suffer	740,000 illnesses

If every illness requires at least one doctor call the nine million people of California would require at least 6,660,000 calls a year.

But the experience for 1945 of the San Francisco Health Service for County and Municipal employees shows 7.7 calls per patient per year and on this basis the people of California should have a total of 51,282,000 calls per year if the above incidence and experience holds true. Only an adequate medical force can cope with this case load. In the table below the uneven distribution of doctors and hospital beds is shown.

The fact is that not all of the sick go to the members of the medical profession but are divided among other practitioners of the healing arts. Also many of the sick are not treated, either because of inability to pay, distrust of the professions or reliance on simple home remedies and treatments for at least the most simple ailments.

In 1940 according to Public Health Bulletin No. 292 (9) the following distribution of facilities existed in California.

DISTRICTS IN CALIFORNIA SHOWING POPULATION HOSPITAL BEDS PER 1,000 PERSONS AND PHYSICIANS PER 100,000 PERSONS AS OF YEAR 1940

Districts	*Population*	*Beds Per 1,000 Persons*	*Physicians Per 100,000 Persons*
Fresno	346,498	4.4	86
French Camp	142,761	5.4	99
Merced	52,593	6.6	87
Modesto	85,753	5.1	89
Total Fresno Region	627,595	4.9	90
Los Angeles	3,121,212	3.7	177
San Bernardino	274,257	4.7	135
San Diego	349,088	3.9	194
Santa Barbara	103,801	7.1	193
Total Los Angeles Region	3,846,358	3.9	176
Sacramento	266,566	4.2	109
Chico	81,857	1.0	109
Red Bluff	54,664	3.3	97
Grass Valley	22,308	3.5	112
Westwood	23,192	3.5	116
Total Sacramento Region	448,587	3.4	108
San Francisco	1,412,686	5.9	222
Eureka	82,125	5.1	105
Salinas	84,424	4.9	163
San Jose	220,006	6.0	181
Santa Rosa	182,606	4.4	195
Total Bay Region	1,982,847	5.7	207
Total State	6,907,387	4.5	172

Note: Adapted from Public Health Bulletin No. 292, U. S. Public Health Service.

For the indigent of this State the Counties and municipalities provide care. At what expense to the taxpayers may be determined by a study of the records. The State C. I. O.[1] gives the following figures for the year 1943.

EXPENDITURES OF COUNTIES FOR THE OPERATION OF COUNTY HOSPITALS, HOMES FOR THE AGED AND CHRONIC CASES, AND TUBERCULAR CARE—CALENDAR YEAR 1943 *

Counties	*Hospital and County Physician*	*Home for Aged (Chronic Cases)*	*Tubercular Care*
Alameda	$680,214.64	$578,038.88	$227,269.13
Alpine	----------	----------	----------
Amador	----------	28,527.97	13,857.03
Butte	105,249.64	----------	----------
Calaveras	19,783.43	----------	1,794.01
Colusa	77,568.01	----------	11,873.47
Contra Costa	123,230.24	----------	79,746.45
Del Norte	19,190.00	----------	----------
El Dorado	23,503.87	----------	5,242.78
Fresno	577,023.69	34,700.80	129,854.38
Glenn	31,053.30	----------	4,262.21
Humboldt	127,671.11	----------	38,389.26
Imperial	87,049.42	----------	7,465.23
Inyo	----------	18,470.87	----------
Kern	963,172.49	----------	----------
Kings	215,263.45	18,814.98	35,602.70
Lake	9,463.19	----------	----------
Lassen	20,536.53	----------	----------
Los Angeles	6,439,699.96	1,426,078.66	1,562,299.51
Madera	62,991.70	----------	10,807.68
Marin	28,486.48	80,864.33	----------
Mariposa	8,928.52	----------	100.70
Mendocino	----------	28,466.09	----------
Merced	223,689.29	----------	40,361.65
Modoc	34,143.14	----------	----------
Mono	8,284.02	----------	----------
Monterey	265,457.53	----------	----------
Napa	10,442.35	21,349.88	13,922.68
Nevada	71,725.66	----------	17,668.68
Orange	294,262.95	----------	----------
Placer	36,090.49	----------	31,922.68
Plumas	36,762.99	----------	7,190.74
Riverside	354,518.10	----------	----------
Sacramento	640,492.08	14,433.78	207,667.40
San Benito	8,466.43	850.28	----------
San Bernardino	388,756.67	37,539.46	----------
San Diego	816,080.15	107,058.51	28,865.29
San Francisco	2,113,762.17	364,586.08	714,887.46
San Joaquin	742,927.78	----------	128,157.41
San Luis Obispo	161,176.59	----------	32,124.86
San Mateo	260,534.36	41,429.54	76,648.95
Santa Barbara	280,426.94	----------	----------
Santa Clara	579,860.47	67,069.98	----------
Santa Cruz	125,896.46	----------	2,665.55
Shasta	67,821.09	----------	----------
Sierra	3,325.49	----------	6,391.30
Siskiyou	151,466.73	----------	----------
Solano	79,208.89	----------	26,786.72
Sonoma	396,750.56	----------	----------
Stanislaus	263,119.93	----------	62,001.10
Sutter	47,804.23	----------	9,572.31
Tehama	43,906.05	386.80	3,270.20
Trinity	19,542.96	----------	----------
Tulare	129,653.90	40,773.40	99,994.96
Tuolumne	39,634.10	9,145.09	3,871.27
Ventura	301,333.62	----------	8,719.28
Yolo	87,014.31	----------	33,755.72
Yuba	64,953.98	----------	25,388.67
Totals	$18,859,372.13	$2,918,585.38	$3,844,935.03

SOURCE: Social Security Board.

[1] * California C. I. O. Council.

That existing sources would be entirely inadequate for maintaining and improving the health of the people of this State under any prepayment plan covering a large proportion of the population is only another way of saying that under existing conditions facilities are inadequate. Increasing the load by extending the right to service only accentuates the shortage.

Those factors which stand in the way of the poor obtaining medical care have been stated time and again. Either the local or State governments must provide the care at public expense, private charities must provide it, the poor must be fitted into a broad scheme or they must go without.

In our modern community they will not long go without medical care, nor have they in the main since, while there may be an antipathy toward County Hospital care and a feeling that it is not the same or of as high a quality as that afforded paying patients in private institutions an appraisal of the services rendered fails to substantiate any such claim.

SECTION FOUR

MEANS FOR IMPROVING THE HEALTH OF THE PEOPLE

Since this committee is not a court of competent jurisdiction no judgment is passed upon the efficiency of the medical profession nor is such criticism from laymen felt to be germane to the problem before us.

The Commercial Insurance Companies do not have the proprietary interest in the health of the people that may be held to accrue to the medical practitioner whose practice is based on study and personal investment in time, money and materials to make him competent. Yet Commercial Insurance has filled a need and provided protection where it was not otherwise obtainable. If some companies profit unduly through their entrance into this field their regulation is in the hands of the legislature.

The non-profit plans have been successful in widening the scope of service but only the fact that they are non-profit can give sanction to the fact that insofar as such plans are controlled or operated by members of the medical profession the physicians themselves, as entrepreneurs, enter a field denied the commercial companies on the basis of the position stated above.

The position of the State in entering the field can only be supported on a service basis. The argument is weak that the establishing of prepaid medical service under state administration is an exercise of the police power of the State unless this police power extends to the individual; not only in matters of quarantine and sanitation as well as contributions in support of a system to treat him when he is sick, but also to insist that he not only obtains treatments but complies with the directives of his physician. The physician becomes then police officer of the State with such powers conferred upon him to exercise in addition to the treatment of common ailments, which he now possesses only by mutual agreement between him and his patient in cases of a serious nature.

The question then resolves itself to one of expediency and practicality. Can the State, should the State, must the State enter the insurance field; what ills may follow?

If a substantial portion of the population is now without prepaid medical insurance it must be because:

(a) It is beyond economic reach, or

(b) It is not really desired, or

(c) It is unnecessary because private or public charity provides an acceptable substitute, or

(d) The people are not educated to the need or desirability of such insurance, or

(e) It has not been possible for private enterprise to furnish either the service or the insurance widely enough.

If wider coverage under prepaid medical care insurance plans has not obtained because of economic factors which make its price prohibitive to those of low income then we must understand what factors relate to the cost of furnishing the service.

These costs, if they cannot be avoided or lowered by different methods of operation and administration, must obtain as well under a State plan as under private plans.

Whether the costs can be equalized through requiring compulsory contributions calls for careful calculation.

The very figures which can be advanced to show the need for equalization of medical costs are the figures which relate to the costs of providing the service.

If, as is probably the case, one third of the families in this State have yearly income less than $1,500.00 and one third have income between that amount and $5,000.00 then these are the families which it is desired to protect.

Approximately two-thirds of the families in the State then suffer approximately two-thirds of the illnesses and require two-thirds of the hospitalization since the incidence of illness is remarkably constant.

Now as to the class in the lower income bracket the persons in it require the same services, but do not get them, or they obtain them free or at reduced rates because of their economic status.

Making an assumption that the incidence of illness is 600 per thousand persons per year and basing the costs of providing medical care at the arbitrary figure (used only for purpose of illustration) of $10.00 per individual treated we can illustrate the process of distributing costs among the insured as provided by application of the insurance principle.

Income Group	*Number Families*	*Persons Per Family*	*Total Persons*	*Illness Reported*
Under $1,500	1,000	3.4	3,400	2,040
$1,500 to $5,000	1,000	3.4	3,400	2,040
	2,000			
Total Demands				4,080
Per Treatment				$10.00
Total Medical Cost				$40,800.00
Per Family				20.00
Per Person				6.00

Expressing the percentage of cost per family according to income per family at different levels we find that while the costs of medical treatment is equalized the cost of obtaining the coverage is not, when family purchasing power is considered.

Family Income	*Medical Care Cost*	*Percentage of Income*
$500	$20.40	4.08
1,000	20.40	2.04
1,500	20.40	1.36
2,000	20.40	1.02
2,500	20.40	.816
3,000	20.40	.68
3,500	20.40	.58
4,000	20.40	.51
4,500	20.40	.45
5,000	20.40	.41

This illustrates why most of the existing plans do not sell readily to families of low income although to them perhaps the real savings to be effected would rank of highest importance if such families rank just above the class receiving free care.

Again for purposes of illustration let us assume a distribution of a number of families according to income levels on the basis that half receive income of $1,500 per year or less and the others receive more than that amount to the upper figure of $5,000.

Number of Families	*Yearly Income*	*Persons Per Family*	*Total Persons*	*Illnesses Reported*	*Medical Care Cost Per Illnesses**
1,000	$500	3.4	3,400	2,040	$20,400
3,000	1,000	3.4	10,200	6,120	61,200
3,000	1,500	3.4	10,200	6,120	61,200
7,000	Low Income				$142,800
1,000	$2,000	3.4	3,400	2,040	$20,400
1,000	2,500	3.4	3,400	2,040	20,400
1,000	3,000	3.4	3,400	2,040	20,400
1,000	3,500	3.4	3,400	2,040	20,400
1,000	4,000	3.4	3,400	2,040	20,400
1,000	4,500	3.4	3,400	2,040	20,400
1,000	5,000	3.4	3,400	2,040	20,400
	High Income				$142,800

* Using $10.00 as an arbitrary figure.

We are now dealing with a larger group in which the subdivisions have been taken in thousands in order to afford easier calculations. The same assumptions are used as to persons per family and incidence of illness as well as average cost of medical care per case.

But it is necessary to visualize what happens if an attempt is made to furnish the care on a basis of percentage of income disregarding the fact that even 1% of income is a significant amount to the family with a $500 income.

Therefore, we calculate the total income derived from these families in order to determine the amount needed to produce the costs.

Amount needed to provide $10.00 Medical Care to anticipated beneficiaries based on an expectancy of 600 illnesses per 1,000 persons—$285,600.00.

Families	*Yearly Income*	*Total Income*	*Total for Income Class*
1,000	$500	$500,000	
3,000	1,000	3,000,000	
3,000	1,500	4,500,000	
			$8,000,000
1,000	2,000	2,000,000	
1,000	2,500	2,500,000	
1,000	3,000	3,000,000	
1,000	3,500	3,500,000	
1,000	4,000	4,000,000	
1,000	4,500	4,500,000	
1,000	5,000	5,000,000	
			$24,500,000
Total Income			$32,500,000

Since there are total costs of $285,600 and total income of $32,500,000 the percentage of income necessary in such a group is approximately .878%.

The next table shows the relation between averaged costs and contributions based on percentage of income.

Family Income	*Contribution at .878% of Income*	*Averaged Family Medical Cost*	*Saved by Plan*	*Increase by Plan*
500	$4.39	$20.40	$16.01	----
1,000	8.78	20.40	11.62	----
1,500	13.17	20.40	7.23	----
2,000	17.56	20.40	2.84	----
2,500	21.95	20.40	----	$1.55
3,000	26.34	20.40	----	5.94
3,500	30.73	20.40	----	10.23
4,000	35.12	20.40	----	14.72
4,500	39.51	20.40	----	19.11
5,000	43.90	20.40	----	23.50

On the basis of the assumptions made, while the family in the lowest income classification may have paid nothing and would contribute $4.39, nevertheless the reduction from the averaged cost is approximately 75% while the family in the highest bracket makes an increased contribution in excess of 100% of the averaged cost.

Since the actual cost of medical care per individual is at present levels of remuneration to the physician and hospital in excess of the $6.00 arbitrarily used for purposes of illustration in the foregoing tables and since such a large part of the poulation falls into classifications below the Annual Family Income Level of even $4,000 and since incidence of demand may well be higher than that used for purposes of illustration it is easy to understand why proponents of a State Operated System of Prepaid Medical Care advocate:

(a) A proportionate amount of contributions to be paid by employers.

(b) A ceiling on annual earnings above which no contributions would be required.

(c) Allocations by the State to make up deficits.

(d) Organization of Physicians on a Capitation Basis and encouraging group practice and clinical procedures to reduce the cost of individual treatment and care.

The exact distribution of the population according to families and individuals earning at certain levels, the number of adult and minor dependents making up the families and the ratio of children born to these families are not only imponderables but the very masses which must be surveyed are in a constant state of movement and change.

While some medical care is undobutedly better than none and means must be discovered to give not only some but adequate care, where such is not now obtained, a deterioration of all or most of medical care now afforded the people is certainly not an end to be desired merely to secure to a certain portion of the population care they do not now enjoy.

In a community as rich as this State people should not die either from want of food or lack of medical care; yet ambition, industry and thrift are to be encouraged in every individual so that he does first of his own volition those things which he should do to provide for himself and family against sickness and want.

But when through no fault of his own he is unable to procure food or medical attention his fellow citizens find it their indispensable duty to relieve his distress.

To this end it is within the scope of this resolution that an alternative proposal be made for the establishing of a State Medical Service, supported by general taxation, which will provide the finest facilities for treatment of injury and disease and provide maternity and pediatric service on a scale designed to bring strong healthy children into the world and to full stature.

Such service should be free as to the individual and a general charge upon all citizens. Because it is free and a different institution than now exists it can be maintained and operated on a different basis from any charity work, clinic or hospital. What competition it affords the medical profession should be healthy competition and conducive to an increase in skill and knowledge.

Those who prefer to be attended by their private physician, maintain the relationship between him and them and pay for his service on the present basis can continue to do so. Those who believe in the new system would be entitled to use it and should do so since it will not vary materially from what must exist in any plan of prepaid medical care that can be afforded under a scale of contributions reasonable to all classes.

What demand might obtain in such facilities can not be forecast with certainty but the higher the demand the greater would be the evidence that a new method of furnishing medical care has been evolved.

I. S. Falk in his book "Security Against Sickness" makes the statements quoted below which seem to this committee to bear on the problem we have been discussing. At page 332 and following we read:

"As we review the needs and the arguments for one form of insurance or another, one point stands out in especially bold relief. The most important single objection to compulsory—and in favor of voluntary—insurance, which was advanced by the Majority of the Committee on the Costs of Medical Care and which determined their stand against "required" insurance, may be expressed in this form: *there is no sound justification why the state should compel contribution of funds until there can also be an equivalent guarantee for the adequate performance of service. The hasty establishment of a compulsory plan would mean compulsion of contributions without guarantee of service beyond that which is provided by existing agencies. And this is insufficient ground to justify compulsion.*

"Against this weighty argument must be balanced the following: (a) *At the outset, the compulsory insurance need not call for larger funds than are now being spent in the private purchase of medical care; the objective at first is merely to distribute the burden of costs among groups of individuals and to replace variable and uncertain costs by fixed and certain contributions.*

"(b) The "power of the purse" offers the strongest possible opportunities to press for improvement in the means of furnishing medical care; *a compulsory system could be so organized that economic as well as other incentives are offered to practitioners to stimulate improvement of service.* This, it seems, is an important type of argument for compulsory insurance; while offering a solution for the need to distribute the costs under government control, it simultaneously offers the means of increasing and stabilizing professional income, and of providing incentives to more efficient and more qualified service.

"In following the Majority of the Committee, the ideal would be to recommend voluntary systems of groups payment and utilize all possi-

ble means of encouraging—but not requiring—desirable forms of organized, efficient, group practice of the highest quality. Then, when the organization of medical service has progressed to the point where it is possible to guarantee the quality and sufficiency of service, the voluntary system should be made compulsory. But this is frankly a counsel of perfection. What is to encourage the rapid and effective organization of medical facilities? Certainly there is no ground in recent experience to warrant the view that the desired objective will be reached by waiting upon the experiments now in progress. There is as much likelihood that the swirling current of events will lead to the predominance of exploited contract practice as that it will intrench desirable forms of voluntary insurance. Commitment to a voluntary program holds no promise that it will bring us to that threshold which would warrant the establishment of a compulsory scheme. There is little evidence in experience, at home or abroad, to indicate that compulsory insurance may be expected to evolve out of the successes of voluntary insurance. History is on the other side of the argument.

"The reorganization of medical practice which is badly needed will not come of itself, the product of laissez faire. It will come—if at all—only as the fruit of strong and directed labors, the product of compelling forces. Of all the forces which society can muster in a program of medical reformation, the strongest is "the power of the purse." Thus, the case is inverted. Instead of organizing for the payment of medical costs after having achieved improvement of service, society must organize for payment in order to achieve improvement of service. In our opinion, this conclusion—when taken in conjunction with the strictly economic arguments and with the need for the compulsory principle to give an effective implementation to social insurance—tips the beam of the balance in favor of compulsory, as against voluntary, group payment. It compels us to recognize, however, that *a compulsory scheme must be planned in such a way that it calls for contributions and expenditures proportional to the availability of qualified medical facilities. Beyond certain minimum requirements, compulsion should be used in different degrees, calling for larger contributions in one place and for smaller in another, according to local circumstances with respect to the capacity to pay the costs and to furnish good medical care.*

"*Among the essential arguments for compulsory insurance special prominence must be given to the one that voluntary insurance fails to reach the population in need of insurance protection.* That voluntary insurance has actually failed in this respect both in foreign countries and in the United States is a matter of record."

We have italicized portion of the above quotation in order that they may be stated as premises upon which agreement may be reached in order that we may endeavor to find justification either historical or statistical for them or state the position this committee takes in respect to the argument presented.

PREMISE 1. There is no sound justification why the State should compel contribution of funds until there can be an equivalent guarantee for the adequate performance of service.

Comment—Every study made by this committee shows that the facilities for rendering adequate service are not at hand.

This does not mean that the skills of the practitioners are not developed but that a shortage of physical facilities exists which must be relieved before adequate medical care can be obtained under any system—voluntary or compulsory.

Unless the establishing of the facilities is undertaken by the State contemporary with the enactment of a law requiring compulsory sickness insurance the benefits promised can not be furnished.

To undertake to institute a program by areas or to certain classes only is inequitable.

Private enterprise, except under the strongest altruistic motives, is not going to provide facilities which are likely to be expropriated by the State.

PREMISE 2. At the outset, compulsory insurance need not call for larger funds than are now being spent in the private purchase of medical care; the objective at first is merely to distribute the burden of costs among individuals and to replace variable and uncertain costs by fixed and certain contributions.

Comment—It is to be noted that the sense "at first" is twice repeated. No factual information has been advanced in support of the contention that larger funds would not ultimately be required.

It is the opinion of the majority of this committee that after the initiation of a program of compulsory sickness insurance the demand from that portion of the community which has not, heretofore received adequate medical care would be so heavy as to upset previously calculated estimates of cost and result either in curtailment of services or increases in costs or lower payments to practitioners and hospitals.

We have already discussed by means of illustration the differences which may obtain between distribution of costs among groups of individuals and the application of the theory that these averaged cost may be recovered by contributions fixed at a percentage of income or wages.

PREMISE 3. A compulsory system could be so organized that economic as well as other incentives are offered to practitioners to stimulate improvements of service.

Comment—Leisure, fame or fortune—what incentives can be offered the practitioners to stimulate improvement of service?

Medical history abounds with the names of hundreds who have sacrificed not only their own health and fortunes, and their lives as well, to discover in laboratories, fevered swamps, plague spots and festering slums the causes and nature of disease and the treatment by which medicine has conquered disease. Such work goes on for something exists in the souls of such men and women that calls forth that high adventuring the effect of which has caused medicine to advance.

When it is proposed to offer the physician economic security and a guaranteed income either as bait to induce him to conform to a new system of performing his art or as something he can take or get out of the profession only the most credulous can square the proposal with the statement that Compulsory Sickness Insurance will provide doctors with greater income than they now enjoy.

PREMISE 4. A compulsory scheme must be planned in such a way that it calls for contributions and expenditures proportional to the availability of qualified medical facilities. Beyond certain minimum requirements, compulsion should be used in different degrees, calling for larger contributions in one place and for smaller in another, according to local circumstances with respect to the capacity to pay the costs and furnish good medical care.

Comment—Falk was writing probably of a nation-wide scheme. This committee flatly rejects the promise stated above in considering any State plan.

We fail to agree that compulsion should be used in varying degrees.

Local circumstances limiting the capacity to pay the costs and to furnish good medical care force upon the State the obligation of providing the care and the costs are part of the overall costs which must obtain under a State-wide program.

If some communities are to have only the "certain minimum requirements" and others are provided these requirements in full scale then discrimination as between communities would exist which is just as repugnant as that discrimination between persons or classes of the population which it is the intent of proponents of Compulsory Sickness Insurance to eliminate.

PREMISE 5. Among the essential arguments for compulsory insurance special prominence must be given to the one that voluntary insurance fails to reach the population in need of insurance protection.

Comment—This committee agrees with the above statement.

a. For the most part the voluntary plans, except as to individual contracts have failed to reach into rural areas or urban areas at distance from larger centers of population. This is particularly true of those plans affording the advantages of clinical group practice.

b. Costs of voluntary plans and insurance studied are such that protection to all the members of the worker's family becomes a severe financial strain.

Summing up the above: the majority of the committee agree that there is a conflict not only of opinions and interests but also that there are fundamental objections to compulsory insurance, not on the grounds that a large portion of the population does not require more and better medical care but that compulsory insurance will not necessarily provide it without introducing new problems and, perhaps, creating evils of no mean magnitude.

SECTION FIVE

HOSPITAL COSTS

Although the report of the actuary of this committee takes into consideration the costs of hospitalization as derived from experience in plans in operation it is felt that the subject should be investigated from the standpoint of the hospitals. Accordingly this committee through an independent investigator has accumulated data from the operating statements of representative California hospitals.

Statistics from twenty hospitals were obtained. Fifteen of the hospitals, five in Southern California and ten in Northern California, were found to have kept records on a comparable basis and their combined experience is recorded in the accompanying tables. We also include a table showing the break-down of charges of the Los Angeles County General Hospitals.

The first table shows the percentage increase or decrease in various items of expense in the years 1940 and 1944.

FIFTEEN CALIFORNIA HOSPITALS COMPARATIVE STATISTICS 1940 AND 1944

	1940	*1944*	*Percentage Increase or Decrease* *
Net Operating Revenue	$7,669,371	$12,809,555	67
Operating Expenses: Pay Roll	4,208,829	7,589,983	80
Supplies	2,766,062	3,871,474	40
Total Expenses	$7,849,328	$12,411,396	58
Admissions	86,468	111,181	29
Patient Days	852,638	1,051,844	23
Average Length of Stay	9.7	9.2	5 *
Average Cost per Patient Day	$9.21	$11.80	28
Average Cost per Patient	$96.44	$108.56	13

Most significant in the above table is the increase in cost indicating a mounting trend which must lead to a higher charge on the patient or curtailment of personnel if it continues.

Patient days or "load" increased 23% while overall expenses increased 58%. Pay roll increased 80% and cost of supplies 40%. As a result the daily patient cost increased from $9.21 to $11.80.

The cost per patient, however, increased by only 13%, reflecting a decrease in the average length of stay.

FIFTEEN CALIFORNIA HOSPITALS REVENUES AND EXPENSES

Year	*1940*	*1942*	*1944*
Gross Operating Revenue	$8,394,222	$10,595,171	$13,497,792
Deductions from Income	724,851	688,280	688,237
Net Operating Revenue	$7,669,371	$9,906,891	$12,809,555
Operating Expenses	7,849,328	9,859,395	12,411,396
Results of Operations	($179,957)	$47,496	$398,159
1. Normal Bed Occupancy	2,529	2,751	2,868
2. Number of Admissions	86,468	103,200	111,181
3. Patient Days	852,638	975,914	1,051,844
4. Average Length of Stay	9.7	----------	9.2
5. Average Cost per Day	$9.21	----------	$11.80
6. Average Cost per Patient	$96.44	----------	$108.56

FIVE SOUTHERN CALIFORNIA HOSPITALS—DETAIL

Year	*1940*	*1942*	*1944*
Gross Operating Revenue	$3,490,359	$4,648,096	$5,930,527
Less:			
1. Charity Allowance	61,114	75,981	88,472
2. Bad Debts	50,362	51,587	40,880
3. Allowance to Professional and Employees	27,653	19,885	46,348
4. Other	2,256	8,596	13,158
Total Deduction from Income	$141,285	$156,049	$188,858
Net Operating Revenue	$3,349,074	$4,492,047	$5,741,669
Operating Expense:			
1. Pay roll	1,817,091	2,616,011	3,403,958
2. Taxes and Interest	178,954	170,930	141,855
3. Depreciation	233,929	226,345	218,337
4. Food, Supplies and Other Expenses	1,027,156	1,341,606	1,622,758
Capital Expenditures			
1. Debt Retirement	$127,501	$161,980	$89,881
2. New Equipment	42,872	39,756	40,938
3. Renovation and Rehabilitation	3,515	582	87,024
4. Other	3,681	5,358	6,029
Total Operating Expenses	$3,434,699	$4,562,568	$5,660,780
Result of Operations			
1. Normal Bed Occupancy	1,222	1,328	1,330
2. Number of Admissions	38,856	44,697	48,226
3. Patient Days	375,828	425,767	460,186
4. Average Length of Stay, Days	9.5	----------	9.3
5. Average Cost per Day	$9.14	----------	$12.30
6. Average Cost per Patient	$86.83	----------	$114.39

TEN NORTHERN CALIFORNIA HOSPITALS—DETAIL

Year	*1940*	*1942*	*1944*
Gross Operating Revenue	$4,903,863	$3,947,075	$7,567,265
Less:			
1. Charity Allowance	188,627	134,725	132,854
2. Bad Debts	65,605	73,440	84,047
3. Allowance to Professional and Employees	33,697	32,730	39,837
4. Other	2,295,637	291,336	242,641
Total Deductions from Income	$583,566	$532,231	$499,379
Net Operating Revenue	$4,320,297	$5,414,844	$7,067,866
Operating Expense:			
1. Pay roll	$2,391,738	$2,983,272	$4,186,025
2. Taxes and Interest	77,289	90,637	102,448
3. Depreciation	206,696	225,297	263,427
4. Food, Supplies, and Other Expenses	1,738,906	1,997,621	2,198,716
Capital Expenditures			
1. Debt Retirement	---------	----------	----------
2. New Equipment	---------	----------	----------
3. Renovation and Rehabilitation	---------	----------	----------
4. Other	---------	----------	----------
Total Operating Expenses	$4,414,629	$5,296,827	$6,750,616
Result of Operations	(94,332)	118,017	317,270
1. Normal Bed Occupancy	1,307	1,423	1,538
2. Number of Admissions	47,612	58,503	62,956
3. Patient Days	476,810	550,147	591,658
4. Average Length of Stay, Days	10.0	----------	9.1
5. Average Cost per Day	$9.26	----------	$11.41
6. Average Cost per Patient	$92.60	----------	$103.83

The table showing how charges are distributed between various departments of the Los Angeles County General Hospital is on two pages, the second being a continuation to the right of the first page.

The first column of costs on the first page refers to "Ward Service" and the intervening columns to the last two on the following page show distribution of charges (i.e. costs) for other services going to make up the total charge.

Note the proposed increase in the 1945-46 schedule over 1944-45 showing that in this institution also there are mounting costs attending the care of the sick. It should be stated that although the word "charges" is used this is bookkeeping parlance and does not mean that the patient pays the bill.

LOS ANGELES COUNTY GENERAL HOSPITAL

Analysis of Proposed Impatient Schedule of Charges for Fiscal Year 1945-46

Inpatient:	*Ward Service*	*Educational*	*Laboratory*	*Dental*	*X-Ray*	*Radium*	*X-Ray Therapy*
Admitting Ward	$4.64	$.2159	$.2025	$.0081	$.0009	----	----
Burns and Plastic	5.29	.2159	.2025	.0050	.0055	----	$.0077
Communicable Diseases	9.68	.2159	.2025	.0004	.0327	----	----
Diabetic	5.54	.2159	.2025	.0134	.0517	----	.0017
Ear, Nose and Throat	5.45	.2159	.2025	.2350	.3021	----	.0346
Empyema	4.98	.2159	.2025	.0069	.1374	----	----
Eye	4.59	.2159	.2025	.0186	.0777	----	.0026
Genito-Urinary	4.38	.2159	.2025	.0015	.2564	----	.0058
Gynecology	4.95	.2159	.2025	.0022	.0221	----	.0012
Jail	6.48	.2159	.2025	.0592	.2485	----	.0082
Medical	4.42	.2159	.2025	.0054	.1052	----	.0038
Neuro-Medical	4.24	.2159	.2025	.0020	.1116	----	.0002
Neuro-Surgical	5.12	.2159	.2025	.0196	.7530	----	.0020
Obstetrical:							
Mother Only	6.62	.2159	.2025	.0010	.0549	----	----
Infant-Nursery	----	----	----	----	----	----	----
O.B. Infected	5.17	.2159	.2025	.0037	.0310	----	----
Orthopedic	4.49	.2159	.2025	.0038	.2708	----	.0037
Pediatrics	4.57	.2159	.2025	.0007	.0769	----	----
Placement (Infirmary)	5.02	.2159	.2025	----	.0091	----	.0057
Pneumonia	5.02	.2159	.2025	.0030	.0915	----	.0016
Psychopathic	8.37	.2159	.2025	.0018	.0311	----	----
Rectal	4.66	.2159	.2025	.0059	.2995	----	----
Skin and Malaria	4.04	.2159	.2025	.0061	.0311	----	.0022
Surgical	5.32	.2159	.2025	.0009	.0969	----	.0103
Tuberculosis	4.16	.2159	.2025	.0088	.0176	----	.0006
Tumor (Malignancy-Radiology)	4.22	.2159	.2025	.0054	.0178	$.6073	.3452
Venereal Disease	3.36	.2159	.2025	.0243	.0164	----	----
Overall							
Obstetrical (alternate method):							
Mother Only							
Infant-Nursery							

Note: It is suggested that the "Admitting Ward" take the "Medical" rate and the "O. B. Infected" take the "Gynecology" rate since mothers on the O. B. Infected are charged as a matter of policy at the "Obstetrical" rate.

LOS ANGELES COUNTY GENERAL HOSPITAL—Continued

Analysis of Proposed Impatient Schedule of Charges for Fiscal Year 1945-46

Inpatient:	*Ambulance*	*Mortuary*	*Transfusion*	*Surgeries*	**Extraneous*	*Proposed Schedule 1945-46*	*Schedule of Charges Eff.8-1-44*
Admitting Ward	$.5181	$.0019	----	----	$.4940	$6.09	$5.66
Burns and Plastic	.0219	.0213	$.0785	$.3137	.4488	6.61	6.06
Communicable Diseases	.0760	.0339	.0052	.1570	.6607	11.07	10.50
Diabetic	.0569	----	.0115	.2297	.4456	6.77	6.30
Ear, Nose and Throat	.0959	.0127	.0098	.7834	.5329	7.88	6.48
Empyema	.0507	.0190	.0731	.5515	.4835	6.72	6.21
Eye	.0379	.0036	.0009	.9515	.5003	6.61	5.88
Genito-Urinary	.0642	.0365	.0308	1.0244	.5288	6.75	5.81
Gynecology	.0826	.0126	.0883	1.1090	.5248	7.22	6.84
Jail	.0065	.0190	.0025	.0175	.3397	7.71	8.29
Medical	.1374	.0995	.0207	.0705	.4585	5.74	5.20
Neuro-Medical	.1222	.0976	.0190	.1227	.4603	5.60	6.44
Neuro-Surgical	.1783	.0484	.0336	.3756	.5314	7.48	6.58
Obstetrical:							
Mother Only	.0602	.0612	.0438	4.0785	.7607	12.10	11.08
Infant-Nursery	----	----	----	----	----	1.00	1.00
O.B. Infected	.1221	----	.1266	1.7999	.5866	8.26	7.22
Orthopedic	.1092	.0126	.0220	1.1122	.5413	6.99	6.33
Pediatrics	.0114	.0246	.0290	.0371	.4283	5.60	5.78
Placement (Infirmary)	.0395	.0053	----	.0186	.4218	4.10	4.06
Pneumonia	.1595	----	.0132	.0254	.4469	6.18	5.77
Psychopathic	.1611	.1221	----	.3445	.5815	9.93	9.10
Rectal	.0715	.0147	.0285	.9830	.5287	7.01	6.38
Skin and Malaria	.0333	.0087	.0029	.0844	.4287	5.06	4.72
Surgical	.0679	.0344	.0922	1.3960	.5535	7.99	7.44
Tuberculosis	.0096	.0189	.0002	.0160	.2681	4.92	4.53
Tumor (Malignancy-Radiology)	.0674	.0400	.0120	.4540	.5388	6.73	6.50
Venereal Disease	.0287	----	----	.7295	.4794	5.06	3.99
Overall						$6.64	$6.31
Obstetrical (alternate method):							
Mother Only						$7.95	$7.66
Infant-Nursery						$3.97	$3.83

Note: It is suggested that the "admitting ward" take the "medical" rate and the "O. B. Infected" take the "Gynecology" rate since mothers on the O. B. Infected are charged as a matter of policy at the "Obstetrical" rate.

* Extraneous column covers depreciation, compensation insurance, interest on bonded indebtedness, public liability and property damage.

SECTION SIX

COSTS OF PROVIDING HEALTH CARE

THE REPORT OF THE ACTUARY OF THE COMMITTEE

In reading the following report which represents the major portion of the work performed by the actuary of this committee it must be remembered that a few columns of figures on a single page may often reflect weeks of accumulating and tabulating data, its analysis and evaluation.

Also that it is founded upon the actual experience of firms and organizations providing that amount of protection afforded the public or groups of employees through the voluntary plans and commercial insurance in force today.

Previous attempts to determine the amount of money spent by the families in California or in the United States have been based either on surveys in which a sample, small or large, has been taken and the average assumed to apply to the entire population or all the reported expense or costs of institutions or practitioners added together and divided by the number of the population to obtain an average cost.

The fact of the matter is that under any proposed plan it must first be determined what services will be offered. From the data here presented valid estimates may be made with the exception of those items pertaining to maternity and obstetrical care and minute segregation of particular ailments.

It must be remembered that the costs vary as among the various plans and a final figure must be taken based on these costs and modified according to prevailing rates then existing if such calculations are made in the future at a date very far removed from today.

While much of the matter in the appendices to the actuarial report may seem lengthy it is included because it demonstrates how difficult it is to compare one form of coverage with another.

Another thing that should be kept in mind is the fact that in the presentation by Samuel C. May in the study "Financial Aspects of Health Insurance" which was furnished the Legislature at the fifty-sixth session the distinct impression was given that the San Francisco Plan furnished a working formula of cost and experience which might be applied state-wide to the employed population.

No attention was called to the fact that this plan does not include obstetrical care or hospitalization in maternity cases for dependent members and that there are restrictions in the contract for minor dependents which exclude operations for adenoids and tonsilectomies.

REPORT

TO THE

ASSEMBLY HEALTH CARE INVESTIGATING INTERIM COMMITTEE, HON. ERNEST R. GEDDES, CHAIRMAN

By

VIRGIL M. GRIFFIN, *Actuary*

INTRODUCTION

The Purpose of this report is the study and discussion of the following:

A. Incidence of Illness: The extent of Health Care Requirements.

B. Facilities: Kind and amount required to meet the Health Care Demand.

C. Cost: The Financial Requirements of Health Care.

These elements are interdependent and each must be considered in relation to the others. A large part of the discussion is based on the recent experience of the various sources described. In any such actual experience the three elements are in a certain state of balance. If a change occur in any one, a corresponding but not precisely predictable change will be brought about in the other two.

Most of the factual data presented is drawn from experience during 1943 and 1944, a period in which there were extraordinary social and economic conditions. There was full employment at high wages with exceptional income derived from overtime, great demand, and high prices; the population was increasing, while the number of practicing physicians was decreasing; and there was an abatement in the normal increase of medical care facilities. The over all effect as reflected by the experience under discussion would be difficult to evaluate. However, in general, the increase in ability to pay for medical services would have effected an increase in the demand for them as is indicated by any study of relative amounts spent for medical care by income groups, while the existing shortage of physicians and the inadequacy of medical care facilities would have tended to decrease the recorded incidence of demand.

The sources of the experience studied, may be grouped into four general types of "Plan."

Type I, so designated for convenience of reference, may be described as noncontractual individual service. The patient usually makes a separate arrangement with physician, clinic or hospital for service, and is personally obligated for the fees and charges. Questionnaires were sent out to a number of physicians practicing in California, and their answers with respect to incidence, facilities and cost recorded.

Type II may be called "Insured Plans" being offered by insurance companies. They undertake to assume in advance a specified amount of the obligation of the patient to the physician or hospital. In theory, and usually, they do not undertake to pay all the expenses of health care but such stipulated amounts of it as the premium paid justifies. Very often, however, the amounts allowed under the contract represent full payment.

In practice the coverage varies greatly. It is often tailored to fit the desire of the applicant and a premium charged accordingly. It may cover hospitalization only with widely differing limits such as $3.00 to $10.00 per hospital day and with few or many expressed restrictions such as noncoverage of obstetrics, tonsilitis, hernia and the like. It may represent very liberal coverage such as physicians fees for calls, after the first three for disease, and all for accident, $6.00 or more per day for each day of hospitalization with limits of from 30 to 90 days, payment or surgical fees limited according to a stipulated "Schedule of Operations" with maximum of $150.00 to $225.00 and in some cases, indemnity

for loss of time due to accident or disease. The contracts may be entered into with individuals or with groups. From a standpoint of a discussion of adequate or near adequate medical care, the group coverage is by far the more important. Two such California groups are described herein, and their experience, as far as possible from the data available, presented. It should be pointed out that in the administration of insured groups little or no attempt is made to control medical, surgical, or hospital fees, and service is contracted for by the individual practically as in Type I.

Type III and IV are prepaid medical care plans, and differ mainly in their methods of operation. Type III undertakes to pay fees and charges for medical, surgical and hospital benefits as stipulated by contract. It differs from all insured plans in two major respects. First, it undertakes to pay all medical expenses except as limited and restricted by contract. Second, it enters into agreements with physicians, surgeons, and perhaps hospitals, with respect to their fees and charges, and exercises more or less control as to the kind and amount of service rendered. The experience for certain periods of two such plans is included herein, that of the California Physicians Service, and that of Health Service System of San Francisco. In the payment of physicians' and surgeons' fees, both of these organizations employ the point schedule system, and may be kept solvent by a variation in the monetary value of a unit service. In a sense, therefore, the impaneled physicians underwrite the financial structure of the plan.

Type IV is similar to Type III in the scope of service rendered. It differs from Type III in that the doctors are employees of the organization. They receive salaries and perhaps other remuneration depending on the financial success of the plan. Its methods of operation lends itself more readily to close control and immediate supervision than any of the other types. Some extracts from the experience of two of these plans are included here: the Roos-Loos Medical Group, and Permanente Foundation Hospitals. Permanente operates its own hospital. Roos-Loos, like all the other plans mentioned, relies upon general hospitals for service.

An analysis of the methods of operation of these types, discloses that they differ as to management, control, and scope of service. Since, with few exceptions, they are commercial or are dependent on volume, some expense is incurred in an effort to gain membership. The acquisition expense may vary from nothing up to 50 or more percentum of revenue, and is the largest single factor in the variation of administration expense. From a standpoint of incidence of demand for service and the cost of the service extended, the kind and degree of control is far the most important. Where little or no control is exercised in the doctor patient relationship relative to fees or amount and kind of service, the incidence and total cost of medical care is apt to amount to unpredictable heights. Insurance companies find it necessary to reserve the right to increase rates, decrease benefits, or to cancel the service contracts. The wide difference in cost exhibited by the studies presented under the general heading of "Insured Groups" will illustrate this, but not so strikingly as would studies of some groups no longer insured. In Type I, the control is exercised by the pocket book of the individual. Many studies have

been made of the cost of medical care by income groups and these show a graduated expense of from about $12.00 to over $100.00 per annum per individual. Type II, Insured Groups, are controlled by the contractual limit of the amount of benefits that will be paid for each medical service.

In Types III and IV control is exercised by a medical director who supervises the administration of medical care in accordance with contractual provisions and in questionable cases, in accordance with the policy of operation of the plan. In some instances there is supervision of the doctors in their administration of health care and their use of facilities in doing so, and indirectly, therefore, control of the amount and kind of service to the patient. Type I and II lacking any kind of control over the patient are, as a rule not subject to his complaint of inadequacy of service, but under Type III and IV, if the patient feels his health is being adversely affected, he may complain of the service to the "plan," which usually has machinery set up for the adjudication of complaints.

"Control" as used here refers to the regulation and administration of health care within the contractual obligations of the "plan." With the exception of Type I, no individual plan now operating offers complete health care. All specify by contract exclusions and limitations as to the kind and amount of service that will be given. Some exclusions are common to almost all prepaid or insured plans, such as treatment of accident or disease covered by workmen's compensation. Others, such as treatment of preexisting conditions may or may not be stipulated. Limitations are by no means standardized. Insured plans exhibit a wide variety of limitations and their values are generally reflected in the premium charged. Prepaid plans usually find it necessary to impose limits such as: number of hospital days per illness or per year; length of time a single illness will be treated; number of doctors' calls per month.

Exclusions and limitations function as financial differentials. If the cost of benefits exceeds revenue, some kinds of service may be excluded or limited; if a surplus develops, the service can be liberalized. Most insured and prepaid plans are consequently in a state of change or projected change with respect to the kind and amount of service rendered.

Such flexibility is highly desirable. Experience has shown that the cost of health care can only approximately be predicted. As has been stated, it varies greatly in different groups. It is affected by the general economic conditions of the times. It may vary in different localities and also as has been mentioned, it is a function of the availability of facilities. Although some plans have been in operation for a number of years, prepaid medicine may be said to be in its infancy, and undoubtedly will continue to evolve as do other institutions.

From a statistical standpoint these differences in kind and amount of services given, as well as their state of constant change, add to the difficulty of interpreting and evaluating such experience as has been recorded and is available. Since the services of no two of the sources of experience are identical in degree and scope, no comparison of incidence or cost can be properly made without adjustment. In this report the practice has been followed of setting down the experience just as recorded. An attempt has then been made to analyze it into its common

factors, by means of which it can be readily compared. For this purpose it has been found necessary to employ certain assumptions. These are fully noted in the text, but the following perhaps requires special explanation.

In the discussion of Class IV plans, a device has been used in an attempt to analyze the values of individual treatments. It consists of applying the point credit schedules of C.P.S. or H.S.S. of S.F. (they being generally commensurate) to the various services recorded in the experience of the plans studied. The purpose of this is to find the relative value of a particular service to other services in the same plan, and relative incidence under different conditions. The results obtained can be assigned a dollar value *only conditionally*. The device will be found useful, however, in estimating probable cost under defined conditions.

TYPE I, PRIVATE PRACTICE

A questionnaire containing 14 parts (see form of questionnaire) was sent to 1,600 practicing physicians throughout California. The first 11 questions relate to incidence and cost, and questions 12, 13 and 14 relate to facilities. About 310 replies were received and tabulated. The results as to incidence and cost are shown in the accompanying tables 1 and 2. The results regarding facilities are shown in Table 45.

The names and addresses of the physicians were taken from the "Board of Medical Examiners, Directory, 1945." In localities where there were very few practicing physicians, questionnaires were sent to all of them. In more densely populated areas such as Los Angeles and San Francisco counties, a questionnaire was sent to every fifth physician listed.

For Committee Use		
Rec'd.:		
Code	Tab.	Area

California State Legislature
Assembly Health Care Investigating Interim Committee
Data Survey—Physicians and Surgeons

Name_____Address_____

	Men	*Women*	*Infants under Age 3*	*Children Age 3-18*
1. Estimated average number of patients per week seen and treated by you				
2. Estimated average number of first office calls per week. (New patients or 1 time calls)				
3. Estimated average number of follow-up office calls per week				
4. Estimated average number of complete exams per week				
5. Estimated average number of home calls per week _____City				
Rural				

6. What is your normal fee for an office call?
   (a) First call $_____
   (b) Follow-up call $_____
   (c) Complete physical examination including only blood count and urinalysis $_____

7. What is your normal fee for a home call?
   (a) City $_____
   (b) Rural $_____

8. Remarks: _____

_____

9. If you are a specialist, in what field?_____

10. Do you maintain a private office?

Yes	No	Clinic	Public Bldg.	Medico Bldg.	Home	Share with other

   (a) Number of assistants _____

11. What percent of your office income is derived from office surgery and treatment involving special equipment? _____%

12. In your opinion are there sufficient hospital facilities in your district? _____ Yes | _____ No

13. When physicians now in service have returned to practice, do you anticipate there will be a sufficient number in your district? _____ Yes | _____ No

14. Do you believe there is an inadequacy of medical facilities of any kind in your territory? In what respect? _____

Remarks: _____

_____

Table 1

	Average Number Per Doctor Per Year				
	Men	*Women*	*Children Under age 3*	*Children Age 3-18*	*Total*
1. First Office Calls (Without complete examination)	134	94	0	49	277
2. First Office Calls (With complete examination)	295	377	123	125	920
3. Follow up Office Calls	1,040	1,452	255	349	3,096
4. Total	1,469	1,925	378	523	4,293
5. Percentage of Total	34.2	44.8	8.8	12.2	----

Table 2

1. Average number of calls per doctor per year	
—Office	4,293
—Residence, City	705
—Residence, Country	80
—Total Calls	5,078
3. Average number of office assistants	.6
4. Average fee for Medical Examination	$9.05
5. Average fee for first office call	$4.77
6. Average fee for follow up office call	$3.16
7. Average fee for residence call	
—City	$4.72
—Country	$5.00
8. Percentage of Income derived from office surgery and use of special office equipment	29.5

INSURED GROUPS

GROUP 1—BANK OF AMERICA

The period studied was Feb. 1, 1943 to Feb. 1, 1945. During that time there was an average membership of 7,345 employees, approximately half of whom were female, 2,382 dependent adults, almost all female, and 1,420 families of children. Dependent wives were admitted only up to the age 45 and dependent children between the ages of 3 and 20 inclusive.

There were no benefits for maternity, pregnancy, miscarriage, insanity of a dependent, accidents or illness covered by Workmen's Compensation, dental service except removal of impacted wisdom teeth. See Exhibit A.

The experience had been kept by individual cases in a claims register. The following information was available separately for male employees, female employees, male dependents, female dependents, male children and female children.

(a) Days in Hospital
(b) Surgical cost (as per schedule)
(c) Special Hospital Service Cost, the limit for dependents and the full cost for employees
(d) Miscellaneous benefits cost.

Table 3 below exhibits the experience compiled from the claim register. The exact number of children was not known and the experience is for families of children. All adult dependents may be classed as female, there being very few adult male dependents. The surgical schedule of operations for dependents was defined in the Plan to be two thirds of schedule of operations for employees. The surgical cost for employees appearing in the claim register has been taken to be the full cost. This is not precisely correct for undoubtedly there were instances of a greater cost for an operation than the amount of reimbursement according to the schedule. However, the schedule is a very liberal one and may be

thought of as closely approximating reasonable standard surgical fees. It is probable that the amounts provided by the schedule were accepted as full payment in most cases.

The amount allowed employees for Special Hospital Service ($150.00) is also quite liberal, and costs shown in the register may be taken as the full cost. The amount provided for dependents is comparatively limited and has not been included in the present study.

With respect to employed members the table exhibits a rather complete representation of the actual cost. A table of hospitalization incidence and duration based on the experience of this group has been prepared and included in another section of this report.

If an average cost per day of bedside care be determined or assumed, and used to extend the experience as indicated in the table, the result will be found useful in arriving at comparative cost. Provisionally, $7.00 per day for adults and $7.65 for children, derived from the experience of C.P.S. during 1945, See Table (19), may be considered representative bedside care costs. Applying these figures to the number of hospital days, line (4) of the table, we may extend Table 3 as shown in Table 4.

Table 3

	Male Employees	*Female Employees*	*Adult Dependents (Selected)*	*Families of Children (Selected)*	*Total Employees*
1. Life Years	7,345	7,345	4,764	2,840	14,690
2. Cases of Illness	966	1,130	380	513	2,146
3. Cases of Hospitalized	427	690	251	295	1,117
4. Hospital Days	3,741	5,673	2,648	1,221	9,414
5. Average Stay, Days	8.76	8.22	10.55	4.14	8.43
6. Average Hosp. Days Per Member Per Year	.509	.772	.556	.430	.641
7. Cost—Special Hosp. Service	$21,796	$28,057	----	----	$49,853
8. Cost—S.H.S. Per Case	$51.05	$40.66	----	----	$44.63
9. Cost—S.H.S. Per Member Per Year	$2.97	$3.82	----	----	$3.39
10. Surgical Cases	593	811	233	392	1,404
11. Surgical Fees	$32,604	$55,757	$15,533	$13,197	$88,361
12. Average Surgical Cost per Case	$54.98	$68.75	$66.66	$33.67	$62.94
13. Average Surgical Cost Per Member Per Year	$4.44	$7.59	----	----	$6.01
14. Average Misc. Cost Per Member Per Year	$.14	$.14	$.14	$.14	$.14

Table 4

	Male Employees	*Female Employees*	*Adult Dependents*	*Families of Children*	*Total Employees*
15. Cost of Bedside Care	$26,187	$39,711	$18,536	$9,341	$65,898
16. Average Cost Bed Side Care Per Member Per Year	$3.57	$5.41	$3.89	$3.29	$4.49
17. Cost—Per Member Per Year equals (9) plus (13) plus (14) plus (16)	$11.12	$16.96	----	----	$14.03

GROUP 2—ADEL PRECISION PRODUCTS CORPORATION

The period studied was from September 1, 1943 to September 1, 1944. During that time there was an average membership of 2,266 employed persons, of whom about 40% were female.

There were certain hospital and surgical benefits of a limited nature for maternity. The cost of these has been eliminated in the figures given in the accompanying Table 5. The table exhibits the experience as derived from a claim register similar to the one described in connection with Group 1.

The results may be compared with those in the corresponding table of Group 1. In comparing surgical costs, allowance should be made for the fact, that, in Group 1, the schedule of operations was more liberal than that of Group 2. The surgical costs in the Group 2 table are undoubtedly appreciably more below the actual costs than are the surgical costs shown in the Group 1 table. The cost of "Special Hospital Benefits" in Group 2 is not known.

In order readily to extend the comparison to the costs of "Hospital Bed Care," the same assumption of a daily cost of $7.00 has been made for Group 2 as was made for Group 1, and Table 6 prepared showing results. Table 7 exhibits the experience in the two groups as far as comparable. For this purpose, since the cost of "Special Hospital Service" is not recorded in the experience of Group 2, the average cost of these services was assumed to be the same per case as that of Group 1.

Table 7 indicates that, after suitable allowance be made for additional surgical costs in Group 2, the cost of hospital and surgical care in Group 2 is appreciably higher than that of Group 1, and that the cost for women (exclusive of maternity) is very much greater than for men.

Attention is particularly directed to the incidence of Hospitalization in Group 2. The average hospital days per year is almost twice the "expected" as indicated for a 30-day limit in section "Duration of Hospitalization," Table E.

Hereafter, this group will be referred to as Group 2 of Type 2 plans.

Table 5

	Male Employees	*Female Employees*	*Total Employees*
1. Life Years Experience	1,360	906	2,266
2. Cases Hospitalized	122	123	245
3. Hospital Days	947	1,316	2,263
4. Average Stay	7.76	10.70	9.24
5. Average Hospital Days per Member per Year	.696	1.452	.999
6. Surgical Cases	161	197	358
7. Surgical Cost	$6,272	$10,831	$17,103
8. Average Surgical Cost per Case	$38.96	$54.98	$47.77
9. Average Surgical Cost per Member	$4.61	$11.95	$7.55

Table 6

10. Bedside Care—Cost	$6,629.00	$9,212.00	$15,841.00
11. Bedside Care—Per Member per year	$4.88	$10.17	$6.99

Table 7

	Employed Members					
	Group 1			*Group 2*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
1. Average Stay in Hospital —Days	8.76	8.22	8.43	7.76	10.70	9.24
2. Average Hospital Days per Member per Year	.509	.772	.641	.696	1.452	.999
3. Average Hospital Cost per Member per Year	$6.44	$9.23	$7.88	$10.18	$16.58	$12.39
4. Surgical "Cost" per Case	$54.98	$66.66	$62.94	$38.96	$54.98	$47.77
5. Surgical "Cost" per Member per Year	$4.44	$7.59	$6.01	$4.61	$11.95	$7.55
6. Cost of Hospital and Surgical per Member per Year	$10.88	$16.82	$13.89	$14.79	$28.53	$19.94

CALIFORNIA PHYSICIANS SERVICE

Through the courtesy of the California Medical Association and the officers of C.P.S., a very thorough breakdown of the Experience of California Physicians Service has been made available. Exhibit C contains excerpts from the various contracts offered sufficient to indicate the scope of its services. In the fall of 1943 a review was made of the incidence and cost of service under the present contract, and the results reported to the trustees. In part, the report states as follows:

"Attached hereto are tables setting forth claim experience during the months of June, July and August, 1943. These months are the first in which conversion from full coverage was complete with respect to all members and all groups.

During the period reviewed, all beneficiary members held the surgical contract or the two visit deductible medical rider, and there were also approximately 2,000 C.P.S. hospitalization contracts in force.

C.P.S. membership dues permit analysis of experience by surgical treatments separate from medical treatments. All members have the basic surgical coverage, and in addition some have the two visit deductible medical coverage as a rider, for which additional membership dues are charged. The contracts in force have been separated into three general classes—namely, surgical, two visit deductible and C.P.S. hospitalization. All surgical treatments have been charged against the income from surgical contracts; all medical treatments have been charged against the income from the two visit deductible medical rider; and all hospital care costs have been charged against the income from C.P.S. hospitalization contracts.

These tables do not take into account administrative costs or reserves, but are based on the general principle that the costs of services rendered should not exceed 75 per cent of the gross income. Administrative costs may vary with changing conditions, and for the purposes of comparison of experience in one period against another, the use of the claims ratio expression eliminates the effects of fluctuating administrative costs.

In analyzing this experience it is well to first consider the composition of C.P.S. membership. The proportion of women among members has increased considerably in the past two years. In 1941 the distribution was approximately 55 per cent women and 45 per cent men. At present there are approximately 70 per cent women and 30 per cent men. This may be wholly or partly the result of the actual change in proportions of men and women in general employment throughout California, but it also confirms the wisdom of setting a differential rates for women members.

There are interesting variations within this general average. In the so-called "large groups" holding surgical contracts, nearly as many contracts are held by men employees as by women employees. In the so-called "small group" surgical contracts, the ratio is one man to two women. Among those carrying surgical contracts on an individual basis after leaving employment, the ratio is one man to more than three women.

Probably because the two visit deductible rider is active in the older groups, the distribution of men and women holding medical riders is a little more favorable—approximately 60 per cent women

and 40 per cent men. However, among those members on individual status who hold medical riders, the proportion is one man to almost four women.

The tables follow a general pattern, setting forth in Column 1 the type of contract—that is, whether it is a man employee, woman employee, two-person contract or three or more person contract.

Column 2 sets forth the number of contracts that are active.

Column 3 sets forth the average cost of services rendered, per contract per month, based upon the average expenditure for the three months. In calculating this cost per contract, the number of units of service rendered has been multiplied by the par value of $2.50 and the expenditures on a dollar basis for X-ray, laboratories added thereto. These costs are representative of what the expenditure would have been were C.P.S. in a position to compensate doctors' services at the $2.50 unit value."

Table 8 below sets forth the results pertinent to this study:

Table 8

California Physicians Service
Experience During June, July and August, 1943

All Contracts

Type of Contract	Surgical Contracts		Med. Riders Two Visit Ded.		Hospitalization		Total Average Cost
	Number of Contracts	Average cost per Contract per Month	Number of Contracts	Average cost per Contract per Month	Number of Contracts	Average cost per Contract per Month	
Male Employees	8,812	.5279	11,229	.5201	330	.5403	1.5883
Women Employees	17,370	.8809	16,949	.8805	1,182	.5847	2.3461
Employee and One Dependent	4,333	1.3929	----	---	226	.5853	1.9782
Employee and Two or More Dependents	4,079	2.5075	----	---	299	1,1808	3.6883

Table 9

California Physicians Service
Experience Under Full Coverage Contracts, All Visits Covered

Year	*Month*	*Members*	*Total Visits*	*Visits per 1,000 Members*
1940	March	9,322	4,210	452
	April	10,868	----	---
	May	11,949	5,664	474
	June	14,065	5,430	386
	July	15,608	5,654	362
	August	16,650	----	---
	September	17,398	----	---
	October	18,561	9,104	491
	November	19,990	9,792	490
	December	20,993	12,603	600
1941	January	21,936	12,327	562
	February	22,948	12,163	530
	March	24,107	14,497	602
	April	24,500	13,584	553
	May	27,057	13,394	495
	June	27,632	13,763	498
	July	28,518	13,137	460
	Total			6,955
	Average Visits per Month per Member			.4968
	Average Visits per Member per Year			5.96

Table 10

		Incidence of Illness %	*Medical Units per Member*	*Surgical Units per Member*	*X-ray and Laboratory Units per Member*
1940	May	16.4	.60	.15	.17
	June	14.2	.48	.13	.13
	July	14.2	.46	.11	.16
	August	14.8	--	--	--
	September	16.9	--	--	--
	October	17.2	.61	.11	.11
	November	17.5	.62	.13	.10
	December	20.4	.81	.11	.10
1941	January	19.8	.75	.14	.05
	February	18.7	.64	.15	.16
	March	19.7	.76	.18	.22
	April	18.1	.67	.19	.18
	May	16.8	.61	.16	.16
	June	16.4	.53	.20	.21
	Average	17.3	.62	.14	.14

Medical units represent the personal services of the physician in office, home, and hospital. Surgical units include fractures and injuries. X-ray and laboratory include diagnostic procedures performed for both ambulatory and hospitalized cases. It also includes X-ray and radium therapy.

Table 11

California Physicians Service
Contract Analysis Register—1945

	April		*July*	
	Contracts	*Persons*	*Contracts*	*Persons*
Medical Riders	----	39,862	----	48,380
Males	----	15,841	----	19,226
Females	----	24,021	----	29,154
Surgical Contracts	72,384	121,961	84,534	143,766
Males	13,318	13,318	15,713	15,713
Females	28,685	28,685	33,814	33,814
2 Person	15,623	31,246	18,416	36,833
3 Person	14,758	48,712	16,591	57,406
C.P.S. Hospital Contracts*	16,571	27,913	18,171	30,552
Males	2,535	2,535	2,796	2,796
Females	7,296	7,296	7,973	7,973
2 Person	3,200	6,400	3,572	7,144
3 Person	3,540	11,682	3,830	12,639

* C. P. S. Hospital Contracts only. Majority of C. P. S. membership holds Blue Cross Hospital Contracts.

	Average Monthly Membership, April to July, Inclusive	*Life Years Exposure*
Medical Riders		
Male	17,534	5,845
Female	26,587	8,862
Total	44,121	14,707

Table 12

California Physicians Service
Units of Service Paid—1945

	Number of Medical Units Paid			
	April	*May*	*June*	*July*
Medical Rider Costs	13,627.0	12,887.3	13,430.0	14,016.4
Attending Physicians	9,349.6	8,848.4	8,890.6	9,262.8
Assistants, Consultants and Anesthetists	92.7	57.0	115.5	106.2
X-ray and Radium	2,424.6	2,546.5	2,810.2	2,686.4
Laboratory and Miscellaneous	1,761.1	1,435.4	1,613.7	1,961.0
Surgical Contract Costs	40,046.8	35,251.6	46,997.8	54,357.2
Attending Physicians	34,243.2	30,332.0	40,811.1	46,988.0
Assistants, Consultants and Anesthetists	5,293.2	4,446.8	5,758.2	6,735.5
X-ray and Radium	496.6	456.4	419.3	615.5
Laboratory and Miscellaneous	13.8	16.4	9.2	18.2
Total Medical Units Paid	53,673.8	48,138.9	60,427.8	68,373.6
Average Unit Value Paid	2.25	2.25	2.22	2.06
Total Paid on Unit Basis	120,766.10	108,312.51	134,149.79	140,849.63
Total Paid on Dollar Basis	29,148.42	46,123.81	33,913.61	39,819.23
Total Medical Costs	149,914.52	154,436.32	168,063.40	180,668.86

Table 13

California Physicians Service
Experience During April, May, June and July, 1945

Month	*Cases of Illness*	*Attending Physician*	*Consultants Assistants Anaesthetists*	*X-ray and Radium*	*Laboratory and Miscellaneous*	*Total Cost*
Male						
April	464	$17,949.85	$2,417.18	$852.70	$839.09	$22,058.02
May	465	14,533.41	1,970.25	1,645.10	1,088.93	19,237.69
June	434	17,346.67	2,168.25	1,088.60	739.60	21,343.12
July	614	21,419.26	2,770.50	1,572.20	1,119.60	26,887.56
Total	1,977	$71,249.19	$9,326.28	$5,168.60	$3,787.22	$89,526.39
Female						
April	557	$26,546.22	$3,464.59	$1,237.75	$1,307.00	$32,555.56
May	580	22,852.52	3,563.00	1,595.10	1,429.52	29,440.17
June	655	29,122.70	4,297.38	1,276.00	1,304.35	36,000.43
July	715	29,249.35	4,701.10	2,034.76	1,764.83	37,750.04
Total	2,507	$107,770.79	$16,026.07	$6,143.61	$5,805.70	$135,746.20
Dependents Under Age 19						
April	456	$13,450.21	$2,062.66	$897.90	$698.79	$17,109.56
May	431	11,286.66	1,786.33	904.67	746.08	14,723.74
June	624	21,407.66	3,737.50	624.47	838.18	26,607.81
July	768	25,076.24	3,723.00	597.00	1,251.71	30,647.95
Total	2,279	$71,220.77	$11,309.49	$3,024.04	$3,534.76	$89,089.06

Table 14

California Physicians Service
Analysis of Physician Visits

MEDICAL RIDERS
(2 visits deductible)

	Cases Handled	*Office Visits*	*Hospital Visits*	*Home Visits*	*Consultation, etc., Visits*	*Total Visits*
April	1,456	4,247	694	176	1	5,118
May	1,529	4,771	615	191	5	5,582
June	1,540	4,688	667	177	3	5,535
July	1,548	4,793	769	191	13	5,766
Total	6,073	18,499	2,745	735	22	22,001
Average per case		3.05	.45	.12	.004	3.62

Life Years Exposure	14,707
Incidence of Use	41.3%
Doctors Calls Per Case	3.62
Doctors Calls Per Member	1.5

Table 15

Experience During April, May, June and July, 1945
Medical Contract—Employed Members

	Male Subscribers		*Female Subscribers*	
Service	*Cost 17,534 Members*	*Cost 1,000,000 Life Years*	*Cost 26,588 Members*	*Cost 1,000,000 Life Years*
1. Cases of Illness	2,667	456,057	5,713	645,569
2. Doctor Visits	7,967	1,362,357	15,946	1,801,898
3. Attending Physician	$22,933	$3,921,633	$53,049	$5,994,588
4. Consultants, Assistants and Anaesthetists	228	39,022	442	49,947
5. X-ray and Radium	8,602	1,470,901	12,128	1,370,516
6. Laboratory and Miscellaneous	6,651	1,137,311	11,757	1,328,526
Total Costs	$38,414	$6,568,867	$77,376	$8,743,577

Table 16

California Physicians Service
Experience During April, May, June and July, 1945
Medical Contract—All Members

	Number or Cost	
Service	*44,121 Members*	*1,000,000 Life Years*
1. Cases of Illness	8,526	579,768
2. Doctors Visits	24,027	1,633,836
3. Attending Physician	$79,105	$5,379,140
4. Consultants, Assistants and Anaesthetists	858	58,344
5. X-ray and Radium	24,994	1,699,592
6. Laboratory and Miscellaneous	20,270	1,378,360
Total Costs	$125,227	$8,515,436

PER ANNUM

Doctors Visits Per Case	2.8
Cost of (3) and (4) Per Member	$5.44
Cost of X-ray, Radium, and Laboratory Per Member	3.08
Cost of (3) and (4) Per Case	9.37
Cost of X-ray, Radium, and Laboratory Per Case	5.31

Table 17

Surgical Contract—All Members

Service	*132,864 Members*	*Per 1,000,000 Life Years*
1. Cases of Illness	8,397	189,772
2. Attending Physician	$348,546	$7,877,140
3. Consultants, Assistants and Anaesthetists	53,086	1,199,766
4. X-ray, and Radium	18,832	425,603
5. Laboratory and Miscellaneous	17,265	390,189
Total Costs	$437,729	$9,892,698

PER ANNUM

Costs Per Member:	
Physician and Assistants	$9.07
X-ray, Radium and Laboratory	.81
Costs Per Case:	
Physician and Assistants	47.77
X-ray, Radium and Laboratory	4.30

Table 18

California Physicians Service
Experience During April, May, June and July, 1945
C. P. S. Hospital Contracts

Service	*Number or Cost 29,232 Members*	*Per 1,000,000 Life Years*
1. Cases of Illness	1,551	159,133
2. Hospital Days	8,562	878,461
3. Ward Care	$63,840	$6,549,989
4. Operating and Delivery Room	21,621	2,218,307
Total Cost	$85,461	$8,768,296
Hospital Days Per Member, Per Year		.878
Ward Care, Cost Per Day		$7.45
Special Services, Cost Per Day		$2.52
Total Cost Per Hospital Day		$9.97
Hospital Cost Per Member, Per Year		$8.77
Hospital Cases Per Member, Per Year		.16
Hospital Days Per Case		5.52
Hospital Cost Per Case		$55.10

Table 19

Membership	*Cases of Illness*	*Hospital Days*	*Ward Care*	*Operating and Delivery Room*	*Total Costs*
All Members	1,551	8,562	$63,840	$21,621	$85,461
Adult Male	301	2,113	14,741	3,684	18,425
Adult Female	487	3,283	23,012	7,529	30,542
Children	466	1,039	7,946	5,242	13,180

	All Members	*Male*	*Female*	*Children*
Hospital Days Per Case	5.52	7.02	6.74	2.23
Cost Ward Care Per Day	$7.45	$6.98	$7.01	$7.65
Cost Special Hospital Services Per Day	2.52	1.74	2.29	5.05
Hospital Cost Per Day	9.97	8.72	9.30	12.70
Cost Ward Per Case	41.14	48.97	47.25	17.05
Cost Special Service Per Case	13.94	12.24	15.46	11.25
Hospital Cost Per Case	55.10	61.21	62.71	28.30

HEALTH SERVICE SYSTEM OF SAN FRANCISCO

The Officers of the Health Service System of San Francisco have submitted a full report of the experience of the Plan for the 12-month period ending 9-30-45, and also the Annual Reports for previous years. The following tables exhibit the experience rather fully. Exhibit D is a description of the services offered.

In Type and manner of administration the Plan is more comparable to C. P. S. than to any of the other Plans herein reviewed. It enrolls Doctors who agree to abide by the rules and regulations of the System, and who are remunerated by the "Point Method," similar to that of C. P. S. A comparison of schedules E and D will reveal the respective scope of services of the two Plans. However, for purposes of interpretation, two differences should be mentioned here. The contract of C. P. S. provides Hospitalization for 21 days for each illness in any contract year with certain additional benefits, while H. S. S. of S. F. provides Hospitalization for 21 days in any twelve month period. C. P. S. excludes the first two visits with respect to medical services for any one illness or injury. H. S. S. of S. F. limits visits by or to the Doctor to maximum of five in any one month.

The membership of H. S. S. of S. F. is limited to the employees of one employer, who reside in a comparatively restricted area. The membership of C. P. S. is composed of the employees of many employers over a wider area. This is an important distinction because experience in Groups is found to reflect the employment policies of the employer and to differ appreciably in different localities. The membership of H. S. S. of S. F. may be said to be "select" in that all new subscribers have been subjected to physical examinations, in connection with their employment. This is not true of Groups in general.

Table 20

Health Service System of San Francisco
Analysis of Contributions and Disbursements per Subscriber per Month by Type of Subscriber
12-Month Period Ending September 30, 1943
Year Ending September 30, 1944

	Employee Members	*Retired Members*	*Adult Dependents*	*Minor Dependents*	*All Subscribers*
Average Monthly Membership	9,918	424	2,721	1,850	14,913
Average Monthly Contribution Per Subscriber	$2.749	$3.321	$2.877	$1.747	$2.664
Disbursements:					
(Average Per Month)					
Doctor Service	$1.667	$2.840	$1.499	$1.340	$1.629
Hospitalization	.537	1.266	.577	.269	.532
X-ray Laboratories	.059	.051	.051	.044	.056
Clinical Laboratories	.032	.024	.031	.050	.031
Ambulance Service	.009	.026	.012	.002	.009
All Medical Service Except Physiotherapy	$2.304	$4.207	$2.170	$1.685	$2.257
Physiotherapy	.032	.032	.032	.032	.032
Total Medical Service	$2.336	$4.239	$2.202	$1.717	$2.289
Non-Medical Expense	.267	.267	.267	.267	.267
Total Disbursement	$2.603	$4.506	$2.469	$1.984	$2.556
Excess of Contributions over Disbursements	$0.146	----	$0.408	----	$0.108
Excess of Disbursements over Contributions	----	$1.185	----	$0.237	----

Table 21

Health Service System of San Francisco

From Annual Report 1943-1944

Analysis of Contributions and Disbursements by Type of Subscribers

Year Ending September 30, 1944

	Employee Members	*Retired Members*	*Adult Dependents*	*Minor Dependents*	*All Subscribers*
Average Monthly Membership	9,544	506	2,534	1,776	14,360
% Each Group to Total	66.5%	3.5%	17.6%	12.4%	100%
Total Membership Contributions Excluding Penalties	$320,708.70	$20,088.80	$88,918.35	$38,373.20	$468,089.05
Disbursements:					
Doctor Service	$199,602.58	$14,328.90	$49,401.50	$28,716.50	$292,049.48
Hospitalization	61,581.80	4,665.97	18,294.50	5,516.40	90,058.67
X-ray Laboratories	9,437.75	382.50	2,197.90	1,244.38	13,262.53
Clinical Laboratories	6,462.00	240.00	1,513.00	1,051.50	9,266.50
Ambulance Service	811.46	106.00	261.50	55.00	1,233.96
Physiotherapy	4,873.23	256.49	1,289.76	908.69	7,328.17
Total Medical Expense	$282,768.82	$19,979.86	$72,958.16	$37,492.47	$413,199.31
Non-Medical Expense	32,390.69	1,704.77	8,572.58	6,039.77	48,707.81
Total Disbursement	$315,159.51	$21,684.63	$81,530.74	$43,532.24	$461,907.12
Excess of Contributions over Disbursements	$5,549.19		$7,387.61		$6,131.93
Excess of Disbursements over Contributions		$1,595.83		$5,159.04	

Table 22

Health Service System of San Francisco

From Annual Report 1943-1944

Analysis of Contributions and Disbursements per Subscriber per Month by Type of Subscriber

12-Month Period Ending September 30, 1944

	Employee Members	*Retired Members*	*Adult Dependents*	*Minor Dependents*	*All Subscribers*
Average Monthly Membership	9,544	506	2,534	1,776	14,360
Average Monthly Contributions Per Subscriber Excluding Penalties	$2.800	$3.310	$2.924	$1.800	$2.716
Disbursements: (Average Per Month)					
Doctor Service	$1.743	$2.360	$1.625	$1.347	$1.695
Hospitalization	.538	.768	.602	.259	.523
X-ray Laboratories	.082	.063	.072	.058	.077
Clinical Laboratories	.056	.040	.050	.049	.054
Ambulance	.007	.017	.008	.004	.006
All Medical Service Except Physiotherapy	$2.426	$3.248	$2.357	$1.717	$2.355
Physiotherapy	.042	.042	.042	.042	.042
Total Medical Service	$2.468	$3.290	$2.399	$1.759	$2.397
Non-Medical Expense	.283	.283	.283	.283	.283
Total Disbursement	$2.751	$3.573	$2.682	$2.042	$2.680
Excess of Contributions over Disbursements	$0.049	----	$0.242	----	$0.036
Excess of Disbursements over Contributions	----	$0.263	----	$0.242	----

Table 23

Health Service System of San Francisco

Distribution of Patients and Cost of Doctor Service and Hospitalization for All Illnesses and Injuries as Classified Under "'Logie' Standard Nomenclature of Human Disease" Year Ending Sept. 30, 1944

Disease	*Patients*	*Total Cost*
Body as a Whole	2,917	$52,796.00
Skin	1,878	28,647.53
Bones, Joints and Muscles	1,489	34,892.08
Respiratory System	2,883	47,252.13
Cardiovascular System	1,374	34,558.82
Blood and Blood-forming Organs	371	6,123.37
Digestive System	2,103	74,454.09
Urogenital System	1,065	64,829.02
Glandular System	33	2,389.62
Nervous System	522	12,729.66
Eye, Ear, Nose and Throat	1,297	15,541.44
Examinations and Deferred Diagnoses	1,224	7,894.39
Total	17,156	$382,108.15

* Includes duplications due to the same subscriber being included in more than one classification. The number of individual patients involved was 9,144.
Average monthly membership 14,360.

Table 24

Health Service System of San Francisco

Comparison by Type of Subscriber of Doctor Service Year Ending Sept. 30, 1944

	Employees Members	*Retired Members*	*Adult Dependents*	*Minor Dependents*	*All Subscribers*
Number of Subscribers In Group	9,544	506	2,534	1,776	14,360
Number Using Service	5,839	373	1,602	1,330	9,144
Per Cent Using Service	61.2	73.7	63.2	74.9	63.7
Average Cost Per Patient Per Year	$34.18	$38.42	$30.84	$21.59	$31.94
Cost Per Member Per Month	1.743	2.360	1.625	1.347	1.695
Total Cost	$199,602.58	$14,328.90	$49,401.50	$28,716.50	$292,049.48

Cost of Doctor Service and Hospitalization for Operative Cases
Year Ending Sept. 30, 1944

	Number of Patients	*Cost*
Removal of Appendix	75	$13,302.19
Other Abdominal Surgery	117	33,876.40
Hernia	54	11,656.96
Resection of Prostate Gland, etc.	18	4,205.15
Nasal Operations	49	2,994.11
Removal of Goiter	20	2,805.97
Fractures	128	19,608.62
Total	461	$88,449.40
Other Operations	1,265	33,190.00
Total Cost of Doctors Service and Hospitalization for Operations (29% of All Medical Costs)	1,726	$121,639.40

Table 25

Health Service System of San Francisco

Comparative Statement Average Monthly Disbursements for Year Ending Sept. 30, 1944, and Sept. 30, 1943

	Year Ended Sept. 30, 1944	*Year Ended Sept. 30, 1943*
Doctor Service	$24,337.46	$24,295.15
Hospitalization	7,504.89	7,930.20
X-ray Laboratories	1,105.21	827.19
Clinical Laboratories	772.21	469.48
Ambulance Service	102.83	137.04
Physiotherapy	601.68	478.73
Total Medical Service	$34,433.28	$34,137.79
*Non-Medical	4,058.98	3,985.63
Total	$38,492.26	$38.123.42

* Includes Medical Director, examination of applicants for dependent membership and Administration expense.

Distribution of Cost of Doctor Service by Type of Service

	Year Ended Sept. 30, 1944		*Year Ended Sept. 30, 1943*	
	Number Calls	*Cost*	*Number Calls*	*Cost*
Office Calls	53,375	$133,437.50	45,360	$112,685.66
Home Calls	9,565	33,477.50	10,097	35,116.86
Hospital Calls	5,259	15,777.00	6,740	20,092.61
Night (Home) Calls	148	1,110.00	156	1,162.63
Total Calls	68,347	$183,802.00	62,353	$169,057.76
Operations		$73,695.65		$77,334.29
Special Service		34,551.83		45,149.71
Total		$292,049.48		$291,541.76

Table 26

Health Service System of San Francisco

Comparison by Type of Subscriber of Cost of Medical Service (Except Physiotherapy) Used During Year Ending Sept. 30, 1944

	Employee Members	*Retired Members*	*Adult Dependents*	*Minor Dependents*	*All Subscribers*
Average Number Subscribers	9,544	506	2,534	1,776	14,360
Number Using Service	5,839	373	1,602	1,330	9,144
Percentage Using Service	61.2	73.7	63.2	74.9	63.7
Average Cost Per Patient	$47.59	$52.88	$44.74	$27.51	$44.39
Cost Per Subscriber Per Month	$2.426	$3.248	$2.357	$1.717	$2.355

Table 27

Percentage Distribution of Receipts

	Year Ended Sept. 30, 1944	*Year Ended Sept. 30, 1943*
Doctors	62.3%	61.2%
Hospitals	19.2	20.0
X-ray Laboratories	2.8	2.1
Clinical Laboratories	2.0	1.2
Ambulance	.3	.3
Physiotherapy	1.6	1.2
Total Medical	88.2%	86.0%
Non-Medical	10.4	10.0
Surplus	1.4	4.0
	100.0%	100.0%

Table 28

Health Service System of San Francisco

Incidence of Illness and Cost by Age Groups of All Medical Service (Except Physiotherapy) Used by Employee Members During Year Ending Sept. 30, 1944

Male Employees

Age	Average No. Subscribers	Per Cent. Using Service	Cost Per Patient	Cost Per Subscriber Per Month
18—29	252	51.2	$38.68	$1.650
30—39	1,327	55.6	33.76	1.565
40—49	1,777	54.6	42.35	1.928
50—59	1,627	57.9	47.83	2.308
60—61	288	57.3	59.58	2.845
62 and over	732	78.1	55.33	3.603
All Ages	6,003	58.6	$44.80	$2.187

Table 29

Female Employees

Age	Average No. Subscribers	Per Cent. Using Service	Cost Per Patient	Cost Per Subscriber Per Month
18—29	241	46.5	$39.67	$1.536
30—39	956	63.7	48.94	2.598
40—49	1,239	64.9	52.67	2.848
50—59	825	69.0	56.27	3.234
60—61	89	73.0	44.85	2.730
62 and over	191	85.3	54.00	3.841
All Ages	3,541	65.6	$51.82	$2.832
Total Members	9,544	61.2	$47.59	$2.426

Table 30

Health Service System of San Francisco

Incidence of Illness and Cost by Age Groups of All Medical Service (Except Physiotherapy) Used by Retired Members During Year Ended Sept. 30, 1944

Male Retired

Age	Average No. Subscribers	Per Cent. Using Service	Cost Per Patient	Cost Per Subscriber Per Month
18—29	---	---	----	----
30—39	4	50.0	$18.00	$.750
40—49	18	72.2	19.69	1.185
50—59	48	43.8	48.36	1.763
60—61	13	76.9	80.29	5.147
62 and over	239	74.1	54.92	3.390
All ages	322	69.3	$53.06	$3.062

Table 31

Female Retired

Age	Average No. Subscribers	Per Cent. Using Service	Cost Per Patient	Cost Per Subscriber Per Month
18—29	---	---	----	----
29—39	3	100.0	$6.67	$.555
40—49	13	92.3	48.27	3.713
50—59	29	79.3	55.20	3.648
60—61	10	80.0	48.53	3.235
62 and over	129	80.6	54.18	3.640
All ages	184	81.5	$52.61	$3.574
Total Retired	506	73.7	$52.88	$3.248

Table 32

Health Service System of San Francisco

Incidence of Illness and Cost by Age Groups of All Medical Service (Except Physiotherapy) Used by Adult Dependents During Year Ended Sept. 30, 1944

MALE DEPENDENTS

Age	*Average No. Subscribers*	*Per Cent. Using Service*	*Cost Per Patient*	*Cost Per Subscriber Per Month*
18—29	34	50.0	$29.93	$1.247
30—39	5	80.0	18.75	1.250
40—49	9	55.6	30.00	1.389
50—59	5	40.0	65.50	2.183
60—61	1	100.0	7.50	.625
62 and over	48	62.5	78.40	4.083
All ages	102	57.8	$54.65	$2.634

Table 33

FEMALE DEPENDENTS

Age	*Average No. Subscribers*	*Per Cent. Using Service*	*Cost Per Patient*	*Cost Per Subscriber Per Month*
18—29	213	59.6	$30.79	$1.530
30—39	533	60.6	43.15	2.179
40—49	687	63.9	47.86	2.549
50—59	504	62.5	41.81	2.178
60—61	79	100.0	43.68	3.962
62 and over	416	60.8	50.03	2.536
All ages	2,432	63.4	$44.36	$2.345
Total Adult Dependent	2,534	63.2	$44.74	$2.357

Table 34

Health Service System of San Francisco

Incidence of Illness and Cost by Age Groups of All Medical Service (Except Physiotherapy) Used by Minor Dependents During Year Ended Sept. 30, 1944

MALE AND FEMALE MINOR DEPENDENTS

Age	*Average No. Subscribers*	*Per Cent. Using Service*	*Cost Per Patient*	*Cost Per Subscriber Per Month*
1— 4	311	74.0	$18.61	$1.147
5— 9	599	80.5	31.33	2.101
10—14	545	65.5	29.18	1.593
15—17	321	81.3	25.99	1.761
All ages	1,776	74.9	$27.51	$1.717

Table 35

Comparison by Type of Subscriber of Cost of Hospitalization Year Ending Sept. 30, 1944

	Employee Members	*Retired Members*	*Adult Dependents*	*Minor Dependents*	*All Subscribers*
Number of Subscribers in Group	9,544	506	2,534	1,776	14,360
Number Hospitalized	781	56	226	111	1,174
Average Days Per Patient	8.2	9.9	8.7	5.1	8.1
Total Days Hospitalized	6,437	553	1,965	570	9,525
Average Days Per Patient	8.2	9.9	8.7	5.1	8.1
Average Cost Per Patient Hospitalized	$78.85	$83.32	$80.95	$49.70	$76.71
Cost Per Patient Per Day	9.57	8.44	9.31	8.68	9.45
Cost Per Subscriber Per Month	.538	.768	.602	.259	.523
Total Cost	$61,581.80	$4.665.97	$18,294.50	$5,516.40	$90,058.67

ROSS-LOOS MEDICAL GROUP

Through the courtesy of Ross-Loos Medical Group its experience for the years 1939 and 1944 was made available. The nature and scope of services to the subscriber and his dependents are described in the "Foreword" to the "Report of the Ross-Loos Medical Group for the year 1939." In part it states as follows:

Nature and Scope of Services to the Subscriber

The service consists of complete medical and surgical care and attention, including professional consultations, treatments, examinations, surgical procedures, preventive care, laboratory procedures, X-ray examinations, physiotherapy treatments, drugs and dressings, hospitalization in a first class hospital for a period not to exceed 90 days in any period of twelve consecutive months, ambulance service and unrestricted physical examinations whenever the subscriber desires them.

It has always been a point of the service that exclusions are kept to the minimum and only the most prevalent of exclusions, such as insanity, chronic alcoholism, drug addiction, social diseases and like items appear in the contract. Injuries arising out of and in the course of the employment of the subscriber and compensable under the Workmen's Compensation Act are not included as part of the service.

The dependent members of the subscriber's family receive special privileges as regards fees for services rendered to them. Some of the fees are at present as follows: Office consultation or treatment, 50¢; physiotherapy treatment, 50¢; residence call, $1.00; gastric analysis test, $1.00; deep X-ray therapy treatment, $1.50; blood chemistry examination, $2.50; rabbit test for pregnancy, $3.00; basal metabolism test, $5.00; electro-cardiogram in office, $7.50; electro-cardiogram in home or hospital, $10.00; minor operation performed in office, including surgery and recovery bed, not over $12.50; confinement case, including prenatal and postnatal care, $20.00; major operation, $25.00 (no charge for any calls made in hospital). All X-ray examinations at rates specified by the Industrial Accident Commission of the State of California.

Location of Offices

In addition to its main headquarters a four story office building in Los Angeles, the Group operates twelve additional offices, eleven of which are in communities well scattered over Los Angeles County and the twelfth is a down town office serving as an auxiliary to the main office. The Group also maintains associate offices in Lone Pine, Independence, Bishop and Victorville, California.

Staff

The Group has always maintained a high standard when considering applicants to the staff. In order that a doctor be considered for the staff it is necessary that he has graduated from a Class A medical school, served an internship in an accredited hospital for a period of one year and in addition thereto served a residency in an accredited hospital for a period of one year or have completed post-graduate work to the equivalent thereof. The Group does not like to consider doctors, excepting specialists, who have been more than seven years

out of college, thereby elminating the possibility of burdening the staff with doctors who have failed to make a success in private practice and are seeking, as a last resort, a berth in a group. Specialists, of course, must have added requirements and each specialist is carefully considered by a committee with particular attention being given to his post-graduate work and subsequent practice in his specialty.

At the present writing the staff consists of 80 doctors, all of whom devote their entire time and attention to this work. There are in addition associate doctors to care for the subscribers in the areas aforementioned. Most of the usual specialists in medicine are covered and include the following: Eye, ear, nose and throat, anesthesia, roentgenology, urology, surgery, ophthalmology, pediatrics, orthopedics, proctology, dermatology, endocrinology, obstetrics, gynecology, cardiology and chest.

The Group makes a practice of employing only graduate registered nurses, registered nurses, registered laboratory technicians, accredited X-ray technicians, and trained physiotherapists. Two prescription pharmacies are operated by the Group, employing six pharmacists and it is an inviolate rule that only preparations fully accepted as classical remedies and manufactured by the foremost pharmaceutical houses are used.

Subscribers

Until quite recently it was the policy of the Group to accept as subscribers only groups of employees of a common employer. However, late in 1938, at the insistence of subscribers who has changed employment and relatives of subscribers who were employed in positions where the service was not available, it was decided to accept individuals as subscribers. The service to the individual is identical to that of the group subscriber, the only difference being that the individual is required to pass a satisfactory physical examination.

At the beginning of the year 1939 the Group had 19,348 subscribers. At the end of the year that figure was 22,728, a gain of 3,380 subscribers or 17.5%. That is somewhat of an improvement over the previous year where the gain was approximately 1,200 less or 12.4%. At the end of 1939 79.5% of the subscribers were male and 20.5% female. At the end of 1938 77.8% were male and 22.2% female. The increase in percentage of male subscribers is probably due to decreasing proportionate strength of teacher groups which are of course predominately female.

At the end of 1939 there were listed on the rolls 46,715 dependents. The average family consisted of 3.05 persons or 2.05 dependents for each subscriber. At the end of 1938 there were 41,197 dependents or 2.1 dependents per subscriber. It is interesting to note that the ratio of dependents has been steadily decreasing for the last three years, the figure at the end of 1937 being 2.2; at the end of 1938 2.1; and 1939 2.05 or a decrease of .1 for 1938 and .05 for 1939. Of the dependents at the end of the year 1939, 29.96% were male and 70.04% were female. At the end of the previous year 29.27% were male and 70.73% were female, indicating that the ratio of sex of dependents remains fairly constant.

Combining the subscriber and dependent strength it is noted that the Group is, in effect, responsible for the complete medical and surgical care and attention of a population of nearly 70,000 persons, a responsibility keenly felt by the group.

Services Rendered

The statistical data in the sheets following sets forth the nature and amount of services rendered to subscribers and their families together with the frequencies of various types of care. It is noted that in 1938 we rendered 124,054 office services, requiring the service of doctors (that is, including such items of X-ray, basal metabolism, laboratory work, etc.) to subscribers, while dependents, who numbered over twice as many, only required 100,563 services. In other words the subscribers availed themselves of 556.80 office services per thousand subscriber months as compared to 221.26 for dependents. During 1939 all services increased slightly for both subscribers and dependents, however, the ratio remained nearly the same, a fact is borne out by the report which shows that in 1939 all services to subscribers were 143,561, to dependents 124,292 or 572.31 for subscribers per thousand subscriber months and 244.08 to dependents per thousand dependent months.

Approximately 38% of the office services rendered to both subscribers and dependents consists of services of specialists. Eye, ear, nose and throat is the specialty most patronized, representing about one-fifth of the office service to the subscriber and about one-seventh of the office service to the dependent.

Attention is directed to the fact that dependents require nearly the same proportionate amount of residence calls as do subscribers. Subscribers, for instance, required 31.04 residence calls per thousand subscriber months for 1939 as against 27.26 for dependents per thousand dependent months. This seems to indicate that even the minimum fee charged dependents serves as a deterrent for using the service for minor conditions. Residence calls being normally acute conditions are considered a necessity and the small fee charged does not cause hesitancy in using the service.

The subscriber makes much greater use of the auxiliary and diagnostic mediums and the percentages which follow are quite illustrative. The following figures are for 1939 only, the difference between the years being so slight that no comparisons are needed:

Refractions	50% to subscribers
Laboratory tests	75% to subscribers
X-ray examinations	60% to subscribers
Electrocardiograms	75% to subscribers
Physiotherapy treatments	70% to subscribers

Hospitalization

During the year we hospitalized 1,155 subscribers and 1,573 dependents. Of that number 551 subscribers and 501 dependents were medical cases. Noting that we hospitalize more subscribers for medical cases than we do dependents demonstrates to a definite degree that we are liberal in our hospitalization to subscribers and are not prone to delay in this respect, whereas the dependent is willing because of the cost to wait for hospitalization until the need is imperative. The average stay in the hospital for surgical cases for

subscribers was 13.2 days and for dependents 10.7. The average stay for medical cases for subscribers was 8.3 days and for dependents 6.1. Comparing the length of stay with 1938, the subscriber's medical stay increased .1 day and surgical stay 2.2 days. The dependent's average surgical stay decreased .1 day and the medical stay was identical.

Surgery

During the year we performed 4,842 minor operations and 1,237 major operations. These figures will conflict with some that will appear later due to the fact that in the later figures procedures on private patients are also included.

The report continues with a table of services rendered to subscribers and dependents, which is reproduced here as Table 36. Table 37 shows the approximate value of the services to subscribers using the point value of similar service allowed by the California Physicians Service. The incidence has been expanded to a basis of 1,000,000 life years exposure for both men and women subscribers. The exposure coverage was determined by averaging the membership at the beginning and end of the year, and the division of exposure between male and female was determined by averaging the percentage of female subscribers at the beginning and end of the year.

The incidence of maternity and obstetrical care of subscribers can not be considered indicative of what might be expected of the general population, inasmuch as most of the subscribers were members of employed groups. The experience pertaining to dependent coverage would also be unreliable as expected incidence, because there was no way of determining what actual proportion of eligible dependents made use of the Ross-Loos Service.

With respect to the subscribers, however, the reasonable assumption may be made that the tabulated experience includes *all* of their medical care within the contract coverage.

The experience of the year 1944 has been tabulated from data furnished by Roos-Loos and expanded to 1,000,000 life years exposure. See Table 38. The monthly membership was known and the average found to be 26,382 subscribers. It is estimated that approximately 1,000 of these were absent in the armed forces and receiving no Ross-Loos service. Accordingly, all incidence and cost per member relative to 1944 experience should be increased about 4%. The proportion of male and female subscribers was not known.

Tables 39, 40, and 41, exhibit the number of services per member per year by kind of service, exclusive of Deep Therapy, Deliveries, and Refractions. The dollars values used conform as nearly as could be determined to the point value allowed for similar service by C. P. S. Relative to this method of valuation please refer to the introductory remarks of this report.

Ross-Loos Medical

Table 36

Nature and Amount of Service Rendered to Subscribers and Dependents per 1,000 of Each Classification

	1938			1939			1938 and 1939		
No. of Subs. or Deps. Months	*Subs. 222,801*	*Deps. 454,512*	*Total 677,313*	*Subs. 250,848*	*Deps. 509,221*	*Total 760,069*	*Subs. 473,649*	*Deps. 963,733*	*Total 1,437,382*
Office Calls (not otherwise specified)	74,300	60,470	134,770	85,466	76,467	161,933	159,766	136,937	296,703
Per 1,000 Each Class	333.48	133.04	198.97	340.71	150.16	213.04	337.51	142.09	206.41
General Examinations	2,055	1,957	4,012	2,348	2,264	4,702	4,493	4,221	8,714
Per 1,000 Each Class	9.23	4.31	5.92	9.72	4.45	6.19	9.49	4.38	6.06
Orthopedics	3,369	3,099	6,468	3,145	3,068	6,123	6,514	6,167	12,681
Per 1,000 Each Class	15.12	6.82	9.54	12.54	6.02	8.17	13.75	6.40	8.82
Dermatology	5,389	3,515	8,904	6,193	3,894	10,087	11,582	7,409	18,991
Per 1,000 Each Class	24.18	7.75	13.15	24.69	7.65	13.27	24.45	7.69	13.21
Urology	6,060	1,810	7,879	7,006	2,001	9,007	13,075	3,811	16,886
Per 1,000 Each Class	27.24	3.98	11.63	27.93	3.93	11.85	27.60	3.95	11.75
Gynecology and Obstetrics	2,358	7,689	10,047	2,384	9,222	11,606	4,742	16,911	21,653
Per 1,000 Each Class	10.58	16.93	14.83	9.50	18.11	15.27	10.01	17.55	15.06
Eye, Ear, Nose and Throat	24,723	14,833	39,556	29,319	17,171	46,490	54,042	32,004	86,046
Per 1,000 Each Class	110.96	32.64	58.40	116.88	33.72	61.17	114.10	33.21	59.86
Surgicals, Dressings, Etc.	5,791	2,675	8,466	7,610	3,909	11,519	13,401	6,584	19,985
Per 1,000 Each Class	25.99	5.99	12.50	30.34	7.68	15.16	28.29	6.83	13.90
Pediatrics	----	4,515	4,515	----	6,296	6,296	----	10,811	10,811
Per 1,000 Each Class	----	9.93	6.67	----	12.36	8.28	----	11.22	7.52
Total Drs.' Office Service	124,054	100,563	244,617	143,561	124,292	267,583	267,615	224,855	492,470
Per 1,000 Each Class	556.80	221.26	331.63	572.31	244.08	352.40	565.00	233.32	342.59
Refractions	2,526	2,329	4,855	4,028	3,997	8,025	6,554	6,326	12,880
Per 1,000 Each Class	11.34	5.12	7.17	16.16	7.85	10.56	13.84	6.56	8.96
Laboratory Tests	13,298	9,704	22,002	15,412	10,478	25,890	28,710	19,182	47,892
Per 1,000 Each Class	59.68	19.15	32.48	61.44	20.58	34.06	60.61	19.90	33.32
X-ray Examinations	5,332	3,502	8,834	6,717	4,552	11,269	12,049	8,054	20,103
Per 1,000 Each Class	23.93	7.71	13.04	26.78	8.94	14.83	25.44	8.36	13.99
Basal Metabolism Tests	718	474	1,192	745	582	1,327	1,463	1,056	2,519
Per 1,000 Each Class	3.22	1.04	1.76	2.97	1.14	1.75	3.09	1.10	1.75

Ross-Loos Medical

Table 36—Continued

No. of Subs. or Deps. Months	*1938*			*1939*			*1938 and 1939*		
	Subs. 222,801	*Deps. 454,512*	*Total 677,313*	*Subs. 250,848*	*Deps. 509,221*	*Total 760,069*	*Subs. 473,649*	*Deps. 963,733*	*Total 1,437,382*
Electro Cardiograms	272	66	338	598	133	731	870	199	1,069
Per 1,000 Each Class	1.22	.15	.50	2.38	.26	.96	1.84	.21	.74
Physio-therapy Treatments	35,419	11,263	36,682	29,982	12,886	42,868	55,401	24,149	79,550
Per 1,000 Each Class	114.09	24.78	54.16	119.52	25.31	56.40	116.97	25.06	55.34
Residence Calls—Night	816	1,177	1,993	1,137	1,872	3,009	1,953	3,049	5,002
Per 1,000 Each Class	3.66	2.59	2.94	4.58	3.68	3.96	4.12	3.16	3.48
Residence Calls—Day	5,823	9,158	14,981	6,651	12,008	18,659	12,474	21,166	33,640
Per 1,000 Each Class	26.14	20.15	22.12	26.51	23.58	24.55	26.34	21.26	23.40
Hospital Calls	18,451	23,389	41,840	29,588	28,404	57,992	48,039	51,793	99,832
Per 1,000 Each Class	82.81	51.45	61.77	117.95	55.78	76.30	101.42	53.74	69.49
Total Hospital and Residence Calls	25,090	33,724	58,814	37,376	42,384	79,660	62,466	76,008	138,474
Per 1,000 Each Class	112.61	74.20	86.83	148.99	83.04	104.81	131.88	78.86	96.33
Minor Operations	2,133	2,607	4,740	2,186	2,656	4,842	4,319	5,263	9,582
Per 1,000 Each Class	9.57	5.74	7.00	8.71	5.22	6.37	9.12	5.46	6.67
Major Operations	467	487	954	554	683	1,237	1,021	1,170	2,191
Per 1,000 Each Class	2.10	1.07	1.41	2.21	1.34	1.63	2.16	1.21	1.52
Confinements	38	337	375	50	389	439	88	726	814
Per 1,000 Each Class	.17	.74	.55	.20	.76	.58	.19	.75	.57
Hospitalizations—Surgical	495	817	1,312	640	1,072	1,676	1,099	1,889	2,933
Per 1,000 Each Class	2.22	1.80	1.94	2.41	2.11	2.21	2.32	1.96	2.08
Hospitalizations—Medical	501	473	974	551	501	1,052	1,052	974	2,026
Per 1,000 Each Class	2.25	1.04	1.44	2.20	.98	1.38	2.22	1.01	1.41
Total Hospitalizations	996	1,290	2,286	1,155	1,573	2,728	2,151	2,865	5,014
Per 1,000 Each Class	4.47	2.84	3.38	4.61	3.09	3.59	4.54	2.97	3.49

Table 37

Ross-Loos Medical Group, 1939

Amount and Value of Service to Subscribers

Services	*Cost Per Unit*	*Number of Services*	*Number of Ser. Per 1,000,000*	*Value Per 1,000,000*	*Number of Services*	*Number of Ser. Per 1,000,000*	*Value Per 1,000,000*
1. Office Calls (not otherwise Specified)	$2.50	56,171	3,392,728	$8,481,820	29,295	6,521,067	$16,302,668
2. General Examination	5.00	1,745	105,398	526,990	693	154,262	771,310
3. Orthopedics	2.50	2,148	129,739	324,348	997	221,932	554,830
4. Dermatology	2.50	4,600	277,840	694,600	1,593	354,602	886,505
5. Urology	2.50	6,261	378,164	945,410	745	165,837	414,593
6. Gynecology and Obstetrics	2.50	0	0	0	2,384	530,678	1,326,695
7. Eye, Ear, Nose and Throat	2.50	21,609	1,305,184	3,262,960	7,710	1,716,246	4,290,615
8. Surgical, Dressings, Etc.	2.50	5,944	359,018	897,545	1,666	370,852	927,130
9. Pediatrics	2.50	0	0	0	0	0	0
10. Refractions	10.00	2,860	172,904	1,729,040	1,168	259,997	2,599,970
11. Laboratory Examinations	2.50	10,076	608,590	1,521,475	5,336	1,187,794	2,969,485
12. X-ray Examinations	10.00	4,500	271,800	2,718,000	2,217	493,504	4,935,040
13. Basal Metabolism Tests	5.00	325	19,630	98,150	420	93,492	467,460
14. Electrocardiogram	7.50	425	25,670	192,525	173	38,510	288,825
15. Physiotherapy	2.50	21,038	1,270,695	3,176,738	8,944	1,990,934	4,977,335
16. Residence Calls—Day	5.00	4,943	298,557	1,492,785	1,708	380,201	1,901,005
17. Residence Calls—Night	7.50	851	51,400	384,500	286	52,564	394,230
18. Hospital Calls	3.00	18,392	1,110,877	3,332,631	7,596	1,690,870	5,072,610
19. Minor Operations	25.00	1,590	96,036	2,400,900	596	132,669	3,316,740
20. Major Operations	100.00	387	23,375	2,337,500	167	37,174	3,717,420
21. Confinements	100.00	0	0	0	50	11,130	1,113,000
22. Hospitalizations, Surgical	100.00	387	23,375	2,337,500	217	48,304	4,830,400
23. Hospitalization, Medical	55.00	425	25,670	1,411,850	126	28,048	1,542,640
Total	-----	164,677	9,946,650	$38,268,267	74,087	16,400,667	$60,631,021

	Male		*Female*	
	Service Per 1,000,000	*Value Per 1,000,000*	*Service Per 1,000,000*	*Value Per 1,000,000*
Totals, omitting 6, 9, 10, and 21	9,773,746	$36,539,227	15,678,862	$55,691,356
Totals Surgical, 19 and 20	119,411	4,738,400	169,843	7,034,160
Totals Hospitalization, 22 and 23	49,045	3,749,350	76,352	6,373,040

Table 38

Ross-Loos Medical Group—Year 1944
Services to Subscribers

Description	*Number*	*Total*
A. Eye, Ear, Nose, and Throat		
1. Office calls, Ear, Nose, Throat	11,282	
2. Office calls, Eye	4,648	
3. Minor operations, Eye	36	
4. Polypectomy	36	
5. Sub-mucous resection	16	
6. Myringotomy	3	
7. Minor operation—Antrum	66	
8. Minor operation—Throat	2	
9. Injections	6	
10. Visual Field	55	
11. Audio	3	
12. Biopsy	2	
13. Setting Fractured Nose	4	
Total		16,159
B. X-ray		
1. X-ray	5,195	
2. Functional X-ray	1,512	
3. Deep Therapy	1,308	
4. Superficial Therapy	1,201	
Total		9,216
C. Physiotherapy		
1. Short wave	12,343	
2. Infra Red	3,654	
3. Massage	3,631	
4. Gilbert stretching	1,707	
5. Galvanic	1,843	
6. Elliatt	190	
7. Ultra Violet	1,779	
8. Gold quartz	242	
9. Long wave	91	
Total		25,480
D. Urology		
1. Office calls	3,542	
2. Injections	1,267	
3. Office treatments	1,520	
4. X-rays	296	
5. Cystos—Simple	139	
6. Cystos—Complete	152	
7. I.V. Pyelograms	8	
8. Surgery (Circumcisions—Child)	56	
9. Spinal	11	
10. Hydrocele	12	
11. Stone manipulation	4	
12. U.R. Caruncle	2	
13. Uteral Dilatation	20	
14. Fulg. of Polyps	13	
Total		7,042
E. Surgeons		
1. Office calls—Gyn.	2,494	
2. Office calls—Surgical	5,150	
3. Minor Surgery	426	
4. Injections	379	
5. Dressings	1,656	
6. Cervical Cautery	21	
7. Rubin Tests	12	
8. Diaphragms	23	
9. General Exams.	7	
10. Consulations	10	
Total		10,178

Table 38—Continued

Ross-Loos Medical Group—Year 1944
Services to Subscribers

Description	*Number*	*Total*
F. Endocrinology—Allergy		
1. Office calls	1,998	
2. Allergy tests	1,016	
3. B. M. R.	833	
4. Hypos.	3,296	
5. I. V. Injections	897	
Total		8,040
G. Proctology		
1. Office calls	3,505	
2. Injections	1,575	
3. Minor surgery	507	
4. Proctoscopy	122	
5. Office treatments	2,509	
6. Hernia Injection	59	
7. Consultation	11	
Total		8,288
H. Dermotology		
1. Office calls	6,944	
2. Dressings	795	
3. Injections	905	
4. Minor surgery	548	
5. CO_2 Snow	47	
6. Patch tests	60	
7. Luetic office calls	104	
8. Autohemotherapy	47	
9. Spinal	6	
Total		9,456
I. Medical		
1. Office calls	22,972	
2. Aspirations	10	
3. Injections	33	
4. Physical Exams.	20	
5. Pneumos	433	
6. Electrocardigrams	857	
Total		24,325
J. Orthopedics		
1. Office calls	2,700	
2. Minor surgery	9	
3. Dressings	180	
4. Splintings	205	
5. Reductions	31	
6. General casts	192	
7. Injections—Novocaine	25	
8. Aspirations	4	
9. Manipulations	12	
10. Taping	220	
11. Elastic Bandages	127	
12. Sling	17	
Orthopedics Total		3,819
K. Surgery		
1. Tonsils and adenoids, General	321	
2. Tonsils and adenoids, Local	146	
3. Mytimogotomy	23	
4. Circumcision (Adult)	10	
5. Minor surgery	105	
6. Cervical operation	54	
7. Spinal punctures	12	
8. Biopsy	33	
9. Vein Ligations	7	
10. Orthopedic surgery	3	
11. Paracentesis	1	
12. Anesthesia	437	
13. Bronchography	9	
14. Lip resection	2	
Total		1,163

Table 38—Continued

Ross-Loos Medical Group—Year 1944
Service to Subscribers

Description	*Number*	*Total*
L. Optometry		
1. Refractions	2,336	
2. Adjustments	1,461	
3. Dispensings	2,057	
4. Disp. Delivery	2,083	
5. Repair	1,082	
Total		9,018
M. Laboratory		
1. Urinalysis	7,770	
2. Hematology	5,442	
3. Parasitology	896	
4. Serology	2,701	
5. Animal Inoculation	142	
6. Functional	290	
7. Biopsy	88	
8. Urine Chemistry	21	
Total		17,350
N. Unclassified		
1. Office calls, Gyn.	133	
2. Office calls, Surgical	1,051	
3. Office calls, Medical	38	
4. Minor surgery	29	
5. Injections	42	
6. Dressings	207	
7. Cervical Cautery	1	
8. Rubin Tests	3	
9. Orthopedics	1	
10. Consultations	66	
Total		1,571
O. Obstetrics		28
P. Pharmacy		74,171
Q. House Calls		2,684
R. Hospitalization		
1. Major operation	389	
2. Minor operation	82	
3. Medical	457	
Total		928
S. Outside Offices		
1. Office calls	34,350	
2. General Exams.	1,104	
3. T. & A.	180	
4. Minor surgery	876	
5. Physiotherapy	8,994	
6. Hypo	9,553	
7. Drugs	27,444	
8. Laboratory	2,382	
9. B. M. R.	438	
10. House calls	2,624	
11. X-ray	24	
Total		87,965
Grand Total		316,881

Table 39

Ross-Loos Medical Group
1944 Experience
Laboratory and X-ray

Description	*Incidence 1,000,000 Life Years*	*Schedule Cost Per Treatment*	*Total Cost*
Laboratory			
Urinalysis	295,260	$1.50	$442,690
Hematology	206,796	5.00	1,033,980
Parasitology	34,048	1.50	51,072
Serology	102,638	3.00	307,914
Animal Inoculation	5,396	7.50	40,470
Functional	11,020	7.50	82,650
Biopsy	3,344	10.00	23,440
Urine Chemistry	798	.50	399
Unclassified	90,516	2.50	226,290
	749,816		$2,219,105
X-ray			
Diagnostic	266,114	$10.00	$2,661,140
Superficial Therapy	45,638	5.00	228,190
	311,752		$2,889,330

Table 40

Ross-Loos Medical Group
1944 Experience

Kind of Service	*Number of Services*	*Services Per Year Per Member*
A. Eye, Ear, Nose, Throat	16,159	.61
B. X-ray	9,216	.35
C. Physiotherapy	25,480	.97
D. Urology	7,042	.27
E. Surgeons	10,178	.39
F. Endocrinology—Allergy	8,040	.30
G. Proctology	8,288	.31
H. Dermatology	9,456	.36
I. Medical	24,325	.92
J. Orthopedics	3,819	.15
K. Surgery	1,163	.04
L. Optometry	9,018	.34
M. Laboratory	17,350	.66
N. Unclassified	1,571	.06
O. Obstetrics	28	--
P. Pharmacy	74,171	2.81
Q. House Calls	2,684	.10
R. Hospitalization	928	.04
S. Outside Offices	87,965	3.33
Total	316,881	12.01

Table 41

Ross-Loos Medical Group
1944 Experience
Physicians Service—Surgery

Description	*Incidence 1,000,000 Life Years*	*Cost Per Service*	*Total Cost*
A. Minor Surgery			
1. Eye	1,368	$25.00	$34,200
2. Polypectomy	1,370	15.00	20,550
3. Sub-mucous resection	608	50.00	30,400
4. Myringotomy	988	7.50	7,410
5. Antrum	2,508	15.00	12,540
6. Throat	76	10.00	760
7. Cystoscopy—complete	5,776	30.00	173,280
8. Circumcision	2,128	15.00	10,640
9. Hydrocele	456	50.00	22,800
10. Stone manipulation	156	50.00	7,600
11. Uteral Dilatation	760	25.00	19,000
12. Urethral Caruncle	76	20.00	1,520
13. Fulg. of Polyps	494	50.00	24,700
14. Reductions	1,178	50.00	58,900
15. Tonsils and Adenoids	12,198	50.00	609,900
16. Vein Ligation	266	30.00	7,980
17. Orthopedic	114	25.00	2,850
18. Paracentesis	38	10.00	380
19. Minor Surgery	98,118	25.00	2,452,950
Total	128,672		$3,498,360
B. Major Surgery	14,782	$125.00	1,847,750
Grand Total	143,454		$5,346,110

Table 42

Subscribers hospitalized:	
Major surgery	389
Minor surgery	82
Medical	457
Total	928
Average days per case	8.2
Hospital days	7,610
Average days per subscriber	.288
Hospital cost	$68,468
Cost per day	$9.00
Cost per subscriber per year	$2.60

PERMANENTE FOUNDATION HOSPITALS

Through the courtesy of the Officers of Permanente Foundation Hospital, the experience of the organization for the year 1944 was made available for this study. Only that experience designated "Health Plan" is here considered. This refers to the prepaid medical and hospital Plan as described in exhibit E. Its membership consisted of Shipyard Employees, and represents about 65% of the services rendered by the Foundation. The other 35%, representing services under various other contracts and for private patients, could not be included because the "exposure" could not be sufficiently established.

"Health Plan" patients were recorded to have been 67.8% of all patients discharged from the hospitals. The number of surgical operations was not segregated, and in this paper it is assumed that 67.8% of the surgery recorded was performed under the Health Plan Contract. Pharmacy dispensings were not segregated, and 66% are regarded as being "Health Plan."

The experience is exhibited in Table (43). One of the most important factors in the valuation of medical care in any group is the percentage of female members. In this experience that percentage is not known.

The group was subject to a high rate of turnover, by which is meant that the average period of membership of its subscribers was comparatively short. In this respect it may be compared with "Adel Precision Products" and contrasted with the "Health Service System of San Francisco." In other respects it is more closely comparable to "Ross-Loos Medical Group" than to any other Plan included in these studies. Two very important differences should be noted. First, the membership of Permanente was from one single employer, and however diversified, such an individual group will reflect its unity as to locality, living conditions, and particularly the policy of the employer in selecting employees. Second, the services of Permanente may be regarded as centering around the Hospital, while those of Ross-Loos center around the Clinic. No practical difference is indicated with respect to services rendered, but there may have been some differences in classification of incidence of hospitalization.

In prepaid medicine organizations that operate as a unit, either Clinic or Hospital, and that retain Physicians on a salary basis, it would not be possible to determine the actual cost of an individual medical service without elaborate accounting. However, since both the Plans of this character studied offer unrestricted use of their services as to calls on the Doctor, Laboratory tests, and X-ray, their recorded incidence provides a fairly reliable basis for estimate of the probable complete requirements.

Table 43

Permanente Foundation Hospitals
Experience—1944

	Number	*1,000,000 Life Years*
Services—Calls		
Number of Subscribers (Health Plan)	64,661	1,000,000
Clinic Calls—First	68,401	1,058,163
Subsequent	210,448	3,255,631
House Calls—Doctor	3,949	61,091
Nurse	7,494	115,932
First Aid Station Visits	396,043	6,126,785
Total Calls	686,335	10,617,602
Services—Non-Hospitalized		
Treatments	278,789	4,312,866
Laboratory Tests	82,806	1,281,009
X-ray Patients (Films)	21,596	334,190
X-ray Therapy	22,794	352,623
Physical Therapy	5,018	77,628
Services—Hospitalized		
Number Hospitalized	7,020	108,599
Hospital Days	49,016	758,278
Days Per Patient	6.98	6.98
Days Per Member	.76	.76
Laboratory Tests	74,206	1,147,967
X-ray Patients (Films)	3,816	59,034
Physical Therapy	2,191	33,894
Services—Surgical		
Minor Surgery	*2,520	38,984
Major Surgery	*1,538	23,793
Services—Miscellaneous		
Pharmacy Dispensings	*116,628	1,804,235
Ambulance and Taxi Trips	10,754	166,364

* Estimated.

DISCUSSION

Facilities

A review of the manner of operation of the Type of Plans described discloses that they differ in theory and practice as regards the provision of Medical Care Facilities. Type I and II rely upon the demand to create the supply. There is no guarantee nor obligation stated nor implied that there will be sufficient facilities to meet the demand. Under Type I, individual agreement, the proper facilities are either apparent or may be assumed by the patient to exist. Very often, however, this assumption is incorrect. The Physician to whom the medical care of the patient is entrusted may not have at his disposal laboratory, hospital, or special equipment facilities indicated for proper treatment. Under Type II, conditions are quite the same. Insured Plans ordinarily do not undertake to provide facilities, but assume that they will be contracted for individually as in Type I. In some instances a group may have at its disposal special clinics, and very often there will be available "company" doctors, but rarely if at all, are these a part of the Insured Plan.

Type III implies, and regularly arranges to provide, a sufficiency of certain basic facilities. Agreements are made with practicing physicians, existing clinics, and hospitals, for the fulfilment of the contractual obligations. The manner of operation is flexible enough to permit a policy of contracting clinics and hospitals. As an example, the Health Service System of San Francisco operates its own physio-therapy unit. At present, however, very little has been done in that direction, and the lack of adequate facilities is one of the major deterrents to expansion of Type III Plans into certain communities.

Type IV, in the nature of its operation, provides special physicians for its members and either a clinic or hospital or both. Since it operates as a "center," in theory it is capable of administering medical care of all kinds, and its existence depends upon its ability to do so. In practice the Plans reviewed are very zealous, as are the Plans of Type III, in providing adequate facilities and the latest improvements in medical care. This type usually operates more or less widely dispersed emergency or sub-clinics with provision for transportation to the "center" when required.

It is obvious that in the absence of sufficient facilities, Type I can function only inefficiently, and no Prepaid Plan would be feasible. It is impractical, therefore, to contemplate any Prepaid Plan publicly or privately operated unless it includes provision for adequate facilities available to the communities of its membership. The question of what would be considered standards of "adequate" facilities is apt to be a provocative one. Its resolution would require investigation with respect to each individual community or region concerned, under the supervision of Medical or Public Health authority.

However, some studies have been made concerning the existing facilities in each county. The results are set forth in Tables (44), (45), and (46). The data in Table (44) was taken from the "American Hospital Directory, 1945," and enumerates the actual facilities reported to exist. Striking inequalities in unit facilities per unit population are brought to view. It is felt, however, that these can be interpreted only in the light of standard requirements set by qualified investigation in each particular

area. The use of county boundaries is merely expedient in an approach to the subject, and investigation would undoubtedly disclose other divisions more efficacious to analysis.

The subject was approached from another viewpoint. Questions 12, 13, and 14, of the Physicians Questionnaire (page 5) were included in an attempt to elicit from the doctors practicing in each area an expression as to the adequacy of facilities. The results are set forth in Table (45). They are sufficient to indicate that inadequacies exist, and to emphasize the need for further investigation.

Table (46) was prepared to find the average foundation or capital cost of a hospital bed and concomitant average hospital facilities. The result is conservative, inasmuch as it is probably based on valuations somewhat under what the actual replacement cost would be at present day prices. It would be inappropriate to estimate the cost of needed facilities on the basis of the need for hospital beds only, as the shortage of other facilities may be proportionately much less or much greater than that of hospital beds.

At present the average capital investment per General Hospital bed together with average General Hospital facilities per bed is apparently in excess of $4,000.00 as indicated in Table (46). There is about one General Hospital bed per 500 population as indicated by Table (44). In both tables the figures for individual counties show considerable deviation from the average.

From Tables (44) and (45) it will be seen that the probable insufficiency of facilities is more pronounced in the rural areas. At the time of these studies there were too few practicing physicians generally, due primarily to the absence of many in the armed services, and it would have been difficult to determine to what extent, in normal times, rural areas are less fortunate than urban in this respect. The statement has often been made that the lack of modern medical facilities in thinly populated districts, accounts to some degree for the reluctance of doctors to practice there. It is a reasonable supposition and accentuates the desirability of improving and augmenting medical facilities available to rural and outlying districts.

Table 44

Nongovernmental General Hospitals
By Counties With Hospital Facilities Reported

County	Population	General Hospitals	Hospital Beds	Population per Bed	Hospital Facilities—Number of Hospitals Having: Blood Bank	Central Supply	Clinical Laboratory	Dental Dept.	Electrocardiograph	Electro-encephalograph	Metabolism	Occupational Therapy Dept.	Out Patient Dept.	Pharmacy	Physical Therapy Dept.	Medical Records Library	Social Service Dept.	X-ray Diagnosis	X-ray Therapeutic	Cancer Clinic	None
Alameda	621,485	11	1,382	450	2	3	10	1	6	1	7	1	2	8	6	9	2	10	8	2	1
Butte	42,054	1	64	657	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Calaveras	6,385	1	12	532	0	0	1	0	0	0	1	0	0	1	1	1	0	1	0	0	0
Contra Costa	218,690	4	177	1,236	0	0	1	0	1	0	1	0	0	1	0	0	0	2	1	0	2
Del Norte	3,461	1	24	144	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
El Dorado	9,961	1	30	332	0	0	1	0	0	0	1	0	1	0	0	0	0	1	0	0	0
Fresno	194,652	8	372	524	0	1	2	0	1	0	3	0	1	3	0	3	0	3	1	0	0
Humboldt	44,106	4	191	231	0	2	2	0	0	0	2	0	1	1	2	1	0	2	0	0	0
Imperial	43,104	1	22	1,959	0	0	2	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Kern	141,541	5	218	649	0	1	2	0	2	0	2	0	2	1	0	3	0	2	1	0	0
Kings	34,397	2	64	537	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Lassen	16,458	2	67	245	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0
Los Angeles	3,138,797	49	5,642	556	12	16	38	3	26	5	35	3	16	28	22	31	9	38	20	7	0
Madera	25,003	2	42	595	0	1	1	0	1	0	2	0	0	0	2	1	0	2	0	0	0
Marin	64,669	2	139	465	0	0	2	0	2	0	2	0	1	0	1	1	0	1	0	0	0
Mendocino	24,514	2	49	500	0	0	2	0	2	0	2	0	0	0	0	1	0	2	0	0	0
Merced	46,632	3	79	590	0	0	3	0	2	1	2	0	1	0	2	2	0	3	0	0	0
Monterey	84,802	6	226	375	0	0	1	0	2	0	2	1	1	1	2	2	0	2	0	0	0
Napa	39,220	2	200	196	0	1	2	0	2	0	3	0	1	1	2	2	0	3	0	0	0
Nevada	13,693	4	79	173	0	1	1	0	2	0	2	0	0	2	0	2	0	2	0	0	0
Orange	153,253	2	155	988	0	2	2	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Placer	24,910	1	28	889	0	0	1	0	1	0	2	0	0	1	2	2	0	2	0	0	0
Riverside	122,235	3	156	784	1	1	2	0	2	0	2	0	0	2	0	0	0	2	0	0	0
Sacramento	188,168	2	502	375	1	2	3	0	3	0	4	1	1	3	2	4	1	4	2	0	0
San Benito	11,717	1	22	533	0	0	1	0	2	0	3	0	0	4	0	4	0	4	2	0	0
San Bernardino	185,081	4	372	498	1	3	4	1	3	0	4	1	1	3	3	4	1	4	3	1	0
San Diego	415,875	7	593	701	1	1	3	1	2	0	3	1	1	3	3	4	1	4	3	1	0

Table 44—Continued

Nongovernmental General Hospitals
By Counties With Hospital Facilities Reported

County	Population	General Hospitals	Hospital Beds	Population per Bed	Hospital Facilities—Number of Hospitals Having: Blood Bank	Central Supply	Clinical Laboratory	Dental Dept.	Electrocardiograph	Electro-encephalograph	Metabolism	Occupational Therapy Dept.	Out Patient Dept.	Pharmacy	Physical Therapy Dept.	Medical Records Library	Social Service Dept.	X-ray Diagnosis	X-ray Therapeutic	Cancer Clinic	None
San Francisco	685,951	14	2,957	232	2	13	9	7	11	4	13	5	11	14	12	14	10	13	12	2	0
San Joaquin	151,805	4	229	663	0	2	1	0	1	0	2	0	1	2	1	2	0	3	2	0	1
San Luis Obispo	39,681	2	60	661	0	1	1	0	1	0	1	0	0	0	1	0	0	2	0	0	0
San Mateo	136,574	2	177	772	1	1	1	0	1	0	1	0	0	1	1	1	0	1	1	0	1
Santa Barbara	74,629	4	370	202	0	2	2	1	2	0	2	0	1	1	2	2	1	1	2	2	1
Santa Clara	191,811	3	291	659	0	2	2	0	0	0	2	0	0	2	0	2	0	2	1	0	1
Santa Cruz	43,709	3	100	437	0	1	3	0	2	1	2	0	1	1	1	2	0	3	0	0	0
Siskiyou	35,049	4	75	467	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	4
Solano	95,615	1	60	1,594	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1	0	0
Sonoma	73,002	3	57	1,281	0	1	0	0	0	0	0	0	0	0	0	0	0	2	0	0	2
Stanislaus	81,348	6	185	439	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	4
Sutter	17,947	1	25	718	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Tehama	12,661	1	40	316	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Tulare	108,283	4	70	1,549	0	0	1	0	0	0	0	1	1	1	0	1	0	3	0	0	1
Tuolumne	8,360	1	23	364	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Ventura	75,992	2	101	752	0	1	2	0	1	0	2	0	0	0	1	2	0	2	2	0	0
Yolo	27,813	1	65	428	0	1	1	0	1	0	1	0	1	1	1	1	0	1	1	1	0
Yuba	18,140	1	36	504	0	1	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0
State	7,902,900	188	15,828	499.9	21	63	107	15	79	13	106	14	47	81	68	96	26	125	66	15	52

Counties Having No Non-Governmental Hospitals

Alpine	216	Modoc	14,259
Amador	6,337	Mono	931
Colusa	8,881	Plumas	9,874
Glenn	10,996	Shasta	26,593
Inyo	16,978	Sierra	1,753
Lake	7,440	Trinity	2,327
Mariposa	3,112		

Table 45

County	Number of Doctors Reporting	Hospital Beds	Inadequacies of Medical Care, Number of Doctors Stating Existence of: Nurses	Office Space	Psychiatrists	Laboratory	Doctors * (General)	Hospital Facilities	Eye Doctors and Specialists	Pathologists	Child Health Care	Ambulances	Inadequate Hospital Supervision	Laboratory or Hospital Fee Too Costly	Facilities for Surgery
Alameda	29	5	3	1	1	1	1	7	0	0	0	0	0	1	0
Amador	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Butte	3	1	0	0	0	1	0	0	0	0	0	0	0	0	0
Colusa	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Contra Costa	3	2	1	0	0	0	1	3	1	1	1	0	0	0	0
Fresno	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Humboldt	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0
Kern	6	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Kings	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Los Angeles	61	8	3	1	1	1	1	13	2	1	1	0	1	1	0
Marin	4	1	1	0	0	0	0	2	0	0	0	0	0	0	0
Monterey	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Mendocino	2	0	0	0	0	0	0	6	0	0	0	0	0	0	0
Merced	3	1	0	0	0	0	1	4	0	0	0	0	0	0	0
Napa	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Orange	15	2	1	0	0	1	0	1	0	0	0	0	0	0	0
Placer	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Riverside	15	4	0	0	0	1	0	2	0	0	0	0	0	0	0
Sacramento	13	1	0	0	0	1	0	0	0	0	0	0	0	0	0
San Bernardino	14	3	1	0	0	0	0	1	0	0	0	0	0	0	0
San Diego	12	6	1	0	0	1	0	1	0	0	0	0	0	0	0
San Francisco	36	1	1	0	0	0	0	2	0	0	0	0	0	0	0
San Joaquin	6	0	0	0	0	0	0	3	0	0	0	0	0	0	0
San Luis Obispo	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0
San Mateo	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Santa Barbara	13	3	2	0	0	0	0	1	0	0	0	0	0	0	0
Santa Clara	13	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Santa Cruz	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Shasta	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Siskiyou	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0

Table 45—Continued

County	Number of Doctors Reporting	Inadequacies of Medical Care, Number of Doctors Stating Existence of: Hospital Beds	Nurses	Office Space	Psychiatrists	Laboratory	Doctors * (General)	Hospital Facilities	Eye Doctors and Specialists	Pathologists	Child Health Care	Ambulances	Laboratory or Hospital Fee Too Costly	Inadequate Hospital Supervision	Facilities for Surgery
Solano	3	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Sonoma	3	0	0	0	0	1	0	2	0	0	0	0	0	0	0
Stanislaus	1	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Tehama	1	0	0	0	0	0	0	1	0	0	0	0	1	0	0
Tulare	6	1	1	0	0	2	0	1	0	0	0	0	0	0	0
Ventura	3	0	1	0	0	0	0	2	0	0	0	0	0	0	1
Yolo	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Yuba	2	0	0	0	0	0	0	0	1	0	0	0	0	0	0
State	308	43	20	10	4	10	14	77	6	1	4	2	6	3	3
Percentage of Totals to Number of Doctors Reporting	%	13.9	6.5	3.2	1.3	3.2	4.2	25.0	1.9	.3	1.3	.6	1.9	.9	.9

Table 46

Foundation Value per Hospital Bed of Nongovernmental General Hospitals

County	Number Reporting	Valuation	Beds	Average for Bed
1. Alameda	7	$6,155,585	1,069	$5,758
2. Calaveras	1	30,000	12	2,500
3. Contra Costa	2	450,000	120	3,750
4. El Dorado	1	-------	---	----
5. Fresno	4	735,574	305	2,412
6. Humboldt	--	-------	---	----
7. Imperial	1	40,000	22	1,818
8. Kern	--	-------	---	----
9. Kings	2	101,000	64	1,578
10. Lassen	1	70,745	47	1,505
11. Los Angeles	35	15,144,076	3,974	3,811
12. Madera	--	-------	---	----
13. Marin	1	394,681	99	3,987
14. Mendocino	--	-------	---	----
15. Merced	1	150,000	50	3,000
16. Monterey	1	35,000	29	1,206
17. Napa	2	672,739	200	3,363
18. Nevada	3	115,000	49	2,347
19. Orange	2	646,965	155	4,174
20. Riverside	2	436,465	126	3,464
21. Sacramento	2	2,245,834	502	4,465
22. San Benito	1	75,000	22	3,409
23. San Bernardino	3	2,262,191	247	9,159
24. San Diego	4	2,621,101	522	5,021
25. San Francisco	13	11,792,344	2,622	4,497
26. San Joaquin	2	250,000	109	2,293
27. San Mateo	1	778,739	141	5,523
28. Santa Barbara	2	1,414,720	233	6,072
29. Santa Clara	3	875,542	291	3,009
30. Santa Cruz	3	371,860	100	3,719
31. Siskiyou	1	40,000	15	2,667
32. Sonoma	2	80,308	45	1,784
33. Stanislaus	1	50,000	35	1,428
34. Tulare	3	125,000	53	2,358
35. Ventura	2	326,190	101	3,229
36. Yolo	1	350,000	65	5,385
37. Yuba	--	-------	---	----
Total	109	$48,836,659	11,424	$4,275

Incidence of Demand for Medical Care

Incidence of Medical Care will be grouped into four divisions: Medical; Laboratory, X-ray, and use of other special equipment; surgical; and Hospitalization.

For the purpose of this analysis Medical may be generally defined as any service other than practical surgery which requires the Physicians time or supervision. Laboratory and the use of X-ray, radium, or special equipment might well be thought of as belonging in this category, but will be considered separately because their use has been found to vary independently of other medical service. Medical may be grouped into one incidence heading of "Doctors Calls" an inclusive term meaning medical examinations, except as they entail laboratory, x-ray, or other special service; office calls; home calls; hospital calls; surgical calls if not included in the surgical fee; physio-therapy; and generally all Physicians services not usually regarded as surgical.

To group so many services of such great inherent possibility of variation will not produce an accurate conception of a single "call," but by far the largest part of them are of a routine character and those that are

extraordinary are considered to be too few to distort the significance of the index of their incidence, if all are considered of indentical value as measured in terms of the physicians time and attention. From a standpoint of incidence a "call" may be considered to be the same phenomenon as another "call," but a monetary value assigned to it, for the purpose of determining the "cost," should be a weighted average based upon some standard of values applied to as many different kinds of service as the data at hand will permit. Some of the assumption herein employed with regard to the comparative number of various kinds of calls are made with an estimation of their value in view.

Table (1) page 6 indicates that under Type I medical care there are about 3.6 calls per illness. This is derived by adding "first calls" to "subsequent calls" and dividing by "first calls." Since each call ordinarily represents additional expense to the patient, the incidence is, as might be expected, lower than that of any prepaid Plan studied. Although it may include some unnecessary calls, it may be regarded as an absolute minimum, and is very probably much below the minimum requirements of adequate medical care.

The Type II Plans providing medical benefits that were available for study were all "three—call deductible" with reference to disease, and the experience applicable only to benefits with the same restriction.

Type III Plans in general exhibit the common characteristics of imposed restrictions, or limitations of Doctors Calls. Some Plans have in the beginning attempted to provide unlimited service but, as exemplified by the Plans described in the present study, have generally found a change of policy necessary in this respect. The Health Service System of San Francisco limits Doctors Calls to a maximum of five in any one month. California Physicians Service originally offered full coverage, now issues only "two call deductible" contracts, which limit the liability to Doctors Calls beginning with the third for any one illness.

In addition, with respect to private practice in general during the period of the experience herein presented, there was an unavoidable curtailment of medical service brought about by an insufficiency in number of practicing physicians due to the absence of many in the armed forces.

In the experience of H. S. S. of S. F. during the year ending Sept. 30, 1944, there was an average of 4.7 doctors calls per member. See Table (25). The percentage of subscribers using service was 63.7. See Table (26). It would appear, therefore, that each subscriber using service required an average of about 7.4 calls, which may be taken as the average number of calls per case.

In the experience of C. P. S. from March 1940 to July 1941, a period in which all calls were covered, the average number of calls per member per year was 5.96, See Table (9), a figure comparable to 4.7 in the paragraph above. During a period from May 1941 through June 1941, there was an average of .62 medical units per member per month. See Table (10), or about 7.44 units per member per year.

The effect of "two call deductible" limitation may be seen in Table (14). The average number of "calls" per member was about 1.5 and the average per case was about 3.62. If, for each *case*, the two disallowed calls be added, the sum of the total calls per case would be 5.62. A seasonal variation has been noted in the experience of C. P. S. with respect to

incidence under the "Medical Rider." The figure of 5.62 pertains to April, May, June and July. For the same months under the full coverage contract, the average number of calls per member was 5.53.

The Type IV Plans yield the most significant experience with respect to unrestricted demand upon the personal services of the Physician. In neither of the two Plans offered for study is there any limitation upon the number of Doctors Calls, and beyond a comparison perhaps of the facility with which individual staff Doctors dispose of their cases, apparently there is little administrative control that would have a limiting effect.

The incidence of Doctors Calls, therefore, as experienced in this Type of Plan, may be considered to be very near the actual demand. As such it is much higher than that experienced in other Types. The experience of the Ross-Loos Medical Group is available for the year 1939 and the year 1944, and of Permanente for the year 1944. For the 1939 Ross-Loos experience there was also data sufficient to determine the division of incidence with respect to male and female employees. This is set forth in Table (37). If from that table there be omitted those services which do not fall in the category of Doctors Calls, there remains an expression of incidence of great importance. The following table (47) has been prepared in this manner and the lines numbered corresponding to Table (37).

The total shows 8.68 services per year per adult male, and 13.82 services per year per adult female. It will be noted that these do not include Gynecology, Obstetrics, Refractions, Dentistry, X-ray, and Laboratory. Some of the Hospital Calls may well be ascribed to Surgical cases. Elsewhere it will be seen that Hospital cases generally may be divided into surgical and medical cases at a ratio of about 1 to 1. See Table (42). If this adjustment were made the incidence totals would then be 8.12 services per year per adult male, and 12.97 services per year per adult female.

A comparison may be made with the reported number of Doctors' and Nurses' services classed as Doctor's Calls, in the 1944 experience of Permanente Foundation Hospital. See Table (43). The incidence of calls is there show to be 10.62 per adult member. The proportion of male and female exposure from which this experience was derived is not known. However, within the range of probable proportions, the incidence is evidently closely comparable to that of Ross-Loos 1939 Experience. As appears in Table (43), the average membership was 64,661, while first calls numbered 68,401 an average of 1.06 cases per member. Since there were 10.6 calls per member the average number of calls per case was about 10. This may be compared with 7.4 calls per case in the experience of H. S. S. of S. F.

The incidence of "use" or the average number of cases per member, is not determinable from the data on hand relative to Ross-Loos experience. A comparison of H. S. S. of S. F. group and the Permanente group in this report shows a spread of from 63.7% in the former to 106% in the latter, a fact which emphasizes what has previously been said concerning the wide difference in the experience of individual groups. In this connection, reference is again made to the difference in costs of the two Type II groups presented. It should be noted that the Permanente index of "use" of 106% is quite conservative, in that it is based on first "Clinic Calls," and excludes "Home Calls," many of which may have been first

calls, and all "First Aid Station Visits," which would undoubtedly include many cases of "use" not referred to the Clinic.

This experience is very impressive and must not be lost sight of in the consideration of expected incidence, but it can not be taken as an index with respect to employed groups as a whole, due, as has been stated, to the fact that it refers to a single group of a single employer. The same objection applies to the experience of H. S. S. of S. F. In conjunction with the experience of Ross-Loos, however, which refers to a more highly differentiated membership, it would appear that the experience of Permanente is not far from the industrial average.

Tables (1) (5) (19) (37) et al. seem to indicate that the incidence of all kinds of medical care of female members exclusive of maternity and diseases peculiar to the female, is about one and one-half times that of employed male members. The ratio appears to hold whether the female members are employed, unemployed, married or single. Tables (29) and (33) show that in the experience of H. S. S. of S. F. the cost per person for female dependents is no more than for female subscribers, although there is probably a much higher percentage of married women among the dependents than among employed female members. The Ross-Loos Medical Group found that the cost of medical care of a female subscriber was about 175% of the cost for a male subscriber. This included, however, certain benefits for maternity. As previously stated in this discussion, the number of Doctors Calls in the Ross-Loos 1939 experience, per year per adult male, was 8.12 and per adult female 12.97, a ratio of a little more than one and one-half to one. As against this we have the experience of H. S. S. of S. F. in Tables (28) and (29), indicating a somewhat lower ratio. In the experience of C. P. S. as shown in Table (8), the cost per adult female contract with respect to medical, was about 175% of the cost per adult male contract, Table (1) shows a ratio of about 45 to 34, less than 1½ to 1, and this, of course, includes all female calls. Standard Insurance Rates are based on the premise that costs for women are 200% of those for men. See "Group Insurance Rates," Schedule F.

There is very little material applicable to the study of medical care requirements of children. The practice of including them with adults in the same contract has tended to obscure the incidence and cost of their medical care demand. It is quite probable too that in future a greater percentage of medical services will be devoted to children than at present. There has been a trend in modern times toward more medical supervision of the young, and these are indications that point to its extension to cover the entire growing period. The most complete experience included in these studies is that of H. S. S. of S. F. Table (26) shows that the incidence of use among children is greater than that of adults, being 74.9 as compared with 63.7 for all subscribers. The service requirement per case is much less as is disclosed by a comparison of cost per case. From Table (1) it would appear that the care of children accounts for about 22% of Doctor's calls.

Conclusions with regard to "Medical" may be summarized as follows:

Under Type I medical care, the demand for doctor's services is much less than under Prepaid Plans, and is measured between 3 and 4 "Doctor's Calls" per person per year.

The use of physicians service is limited under Type II and Type III Plans. With the "two-call deductible" limitation, the Doctor's calls per member average about 1.5 to 2 per year. Without such limitation the

average is about 6 per member per year. With calls limited to 5 within any one month, in a membership including men, women, and children, the average number of Doctor's Calls per person per year is about 4.7 and the number of calls per case about 7.4.

The experience of the Type IV Plans, studied is consistent and indicates the requirements of physicians services, unlimited but administratively supervised, to be about 10 Doctor's Calls per adult member per year, exclusive of maternity care.

The number of medical cases per member per year in individual groups ranges from about .6 to more than 1. In diversified groups the average appears to be near 1.

The total experience shows that women require about 1.5 times as much physicians service (exclusive of maternity care and care of diseases peculiar to women) as men.

In view of the meager experience relative to the use of medical service by children and the possibility of the future expansion of medical child care, no well substantiated estimate of probable requirements can be made, but such evidence as is available indicates that each child under the age of 19 would require about ½ as much service as the adult average.

In a controlled prepaid system, consisting of a membership of men, women, and children, the expectation of unlimited demand for physicians service, as measured by Doctor's Calls per year may be placed at 8 for each man, 12 for each woman and about 5 for each child, or 25 Doctor's Calls for a family of three; the number of cases per member per year at 1; and the number of Doctor's Calls per case at about 8.

It is to be noted (with reference to Table (2) that this represents probably about twice as much physicians service as is now being received under Type I.

Table 47

Incidence of Physician's Personal Services (Except Surgical) from the Ross-Loos Medical Group Experience of 1939

Kind of Service	*Number of Services Per 1,000,000 Life Years*	
	Male	*Female*
1. Office Calls (not otherwise specified)	3,392,726	6,521,067
2. General Examination	105,398	154,262
3. Orthopedics	129,739	221,932
4. Dermatology	277,840	354,602
5. Urology	378,164	165,837
7. Eye, Ear, Nose and Throat	1,305,184	1,716,246
8. Dressings	359,018	370,852
16. Residence Calls—Day	298,557	580,201
17. Residence Calls—Night	51,400	52,564
18. Hospital Calls	1,110,877	1,690,870
19. Physio-therapy	1,270,695	1,990,934
Total	8,679,598	13,819,367
Total (excluding ½ of line 18)	8,124,160	12,973,932

Incidence and Cost of Laboratory and X-ray

The class of medical services treated under the general heading of "Laboratory and X-ray" includes the use of other special equipment. Much of this service is rendered in hospitals, and that part of it will be considered in the "Cost of Hospitalization," for the reason that it is included in the cost of hospitalization in much of the data at hand, as a part of "Special Hospital Services." This discussion will be limited to its diagnostic and therapeutic use in ambulatory cases by a private physician, commercial laboratory, or clinic.

None of the experience here presented relative to Type I or Type II medical care provides any clue as to the extent of the use of Laboratory, X-ray, or service involving other special equipment. Each of the Plans under Types III and IV, however, has provided statistical divisions sufficient for the purpose. These are all set forth in the tables of recorded experience in this report, but for the purpose of comparative analysis have been incorporated in the accompanying Table No. (47).

The California Physician's Service offers complete laboratory and X-ray examinations, X-ray and radium treatments, in its medical contract, and diagnostic X-ray and clinical laboratory service in its surgical contract. The medical contract is issued only to employed subscribers, and during May, June, July, and August, 1945 the cost under it, and $20,270 for laboratory and miscellaneous. See Table (16). If expanded to one year on this basis, the cost per subscriber per year would be $1.70 for X-ray and radium and $1.38 for laboratory. Under the surgical contract with miscellaneous membership, the cost per member during the same period was $.14 for X-ray and radium and $.13 for laboratory. Expanded to one year the cost per member for X-ray and radium would be $.42 and for laboratory $.39. The total cost per member per year, therefore, for all these services would be $3.89. Table (15) indicates the cost for men and women to be about the same.

The contract of the Health Service System of San Francisco limits the use of X-ray and laboratory:

> "X-ray examinations to the value of $10.00 and laboratory tests to the value of $5.00 are given to patients *while not in the hospital,* and are limited respectively to service for any one condition, illness or injury. After twelve month period has elapsed, the service of either or both may be extended, upon approval of the Medical Director, to cover a new condition, illness or injury."

For patients in the hospital the contract stipulates what the patient must pay for if used:

> "* * * the use of radium, deep X-ray therapy, * * * allergic tests, biologic tests * * *."

Its recent experience indicates costs per member per year as follows See Table (22):

	Employed Members	*Dependent Adults*	*Dependent Children*	*All Members*
X-ray	$.98	$.86	$.70	$.92
Laboratory	.67	.60	.59	.65
Total	$1.65	$1.46	$1.29	$1.57

The experience of the Ross-Loos Medical Group is available for 1939 and 1944. Table (39) shows a point valuation of these services and indicates that the average value of laboratory examinations is about $2.50. X-ray examinations are considered to have a value of $10.00 and X-ray therapy treatments $5.00 each. Deep therapy is not included. On this basis of valuation the experience is as follows:

	1939 Male		*1939 Female*	
	Service Per Member	*Cost*	*Service Per Member*	*Cost*
X-ray	.27	$2.72	.49	$4.94
Laboratory	.61	1.52	1.19	2.97
Total	.88	$4.24	1.68	$7.91

The average value per employed member was $5.02.

	Male and Female—1944	
	Service Per Member	*Cost*
X-ray	.31	$2.89
Laboratory	.75	2.22
Total	1.06	$5.11

The experience of Permanente Foundation Hospitals for 1944 is set forth in Table (43). On the same basis of valuation as the above, the cost for non-hospitalized patients would be determined as follows:

	Service Per Member Per Year	*Unit Cost*	*Cost*
Laboratory	1.28	$2.50	$3.20
X-ray (Examination)	.33	10.00	3.30
X-ray (Therapy)	.35	5.00	1.75
Total	1.96		$8.25

Table of Comparative Costs of Nonhospitalized Laboratory and X-ray Service

Plan	*Year*	*Cost Per Member Per Year*
C. P. S.	1940–1941	$4.20
C. P. S.	1944	3.89
H. S. S. of S. F.	1944	1.57 (limited)
Ross-Loos	1939	5.02
Ross-Loos	1944	5.11
Permanente	1944	8.25

The membership of C. P. S. was predominantly female in a ratio of about 1.5 to 1; of Ross-Loos predominantly male in a ratio of about 3.5 to 1; of Permanente, not known.

Considerable variation in cost is noted. To obtain a usable cost figure, an average cost under the unlimited coverage contracts can be taken, and there being insufficient data on which to base a relative cost estimate as between male and female subscribers, the figure can be assumed to apply to each. The average thus determined is $5.29 per member per year.

The determining factors in the amount of use required may be contrasted with those of "Doctor's Calls." The amount of demand for Doctor's Calls" resides largely in the opinion of the member concerning his own state of health, while the extent of use of laboratory, X-ray, and other special equipment depends to a greater degree upon the professional methods of the attending physician or surgeon, and upon the availability of facilities.

Incidence and Cost of Surgery

The discussion of Surgery will be confined to the requirement and cost of the services of Surgeons, Consultants, Assistants, and Anaesthetists.

The cost exhibited in the experience of the Insured Plans is limited to the "Schedule of Operations" which in each case is a part of the Plan. Such Schedules vary in the relative amounts allowed for specific operations. Group 1 included a schedule allowing amounts up to $225.00 for certain operations. Under Group 2 the schedule allowed amounts of about two-thirds of the corresponding amounts under Group 1, with a maximum of $150.00 for any one operation. It can not be stated with certainty what part of the actual charges the amounts allowed under the schedule represent, probably not all under the most liberal contracts, and correspondingly less under the others. For the present purpose, however, the

payments under a schedule of operations with a $225.00 maximum may be considered conditionally to represent the full cost for the reason that the amounts allowed are very close to what under certain conditions could be regarded as reasonable charges for ordinary operations, that is, operations without extraordinary complications that entail unusual demand for service.

Under the Plans of Type III, the point system extends to surgical services and the point values form schedules somewhat similar to those of Insured Plans. They are more flexible, however, in that they make provisions for extra points in cases of extraordinary or unusual requirements. This is in keeping with their purpose which is to fix, by previous arrangement with the Physician, the full amount of payment for services rendered; whereas, in Insured Plans, the amounts in the schedule are simply the limits of contractual liability under the Plan.

Under the Plans of Type IV the costs of the surgical services rendered is not determinable from the data at hand. The incidence, or the number of operations per member per year, is recorded. As an approach to the subject, therefore, the method used in the discussion of "Medical" is considered feasible, that is, first to determine a reasonable expectation of incidence, and then to apply to its actual or assumed average costs per case.

The accompanying Table No. (48) has been prepared to show the number of surgical cases per year per member in each of the Plans for which the experience is available. The two Insured Groups are averaged together for the purpose. The incidence with respect to both male and female exposure is given where available.

Table 48

Incidence of Surgery—Cases per Member per Year

Plan	*Men*	*Women*	*All Members*
Insured	.100	.164	.127
C. P. S. (1945)	---	---	.190
H. S. S. of S. F.	---	---	.120
Ross-Loos (1939)	.119	.170	.130
Ross-Loos (1944)	---	---	.143

It will be seen that the Insured Plans and Ross-Loos 1939 experience agree very closely as to incidence of surgery for both men and women. With respect to "all members," they are in close agreement with H. S. S. of S. F. and Ross-Loos 1944 experience. The incidence in the experience of C. P. S. is much higher. This is not entirely accounted for by the fact that the membership of C. P. S. is predominantly female, while those of H. S. S. of S. F. and Ross-Loos are predominantly male. It is partly due to seasonal variation. Experience has shown that the incidence of surgery is higher in the summer months than in winter, and the C. P. S. figure is based on its experience during April, May, June, and July. The preponderance of experience seems to indicate an incidence of .12 for male and .17 for female participants to be the most probable.

A group consisting largely of new members enrolled without selection might conceivably give rise to a much less favorable experience in the early years.

Hospitalization

No two of the Plans, the experience of which is presented herein, offer the same maximum period of hospitalization:

Insured Group 1, 10 weeks (70 days).

Insured Group 2, 31 days.

C. P. S., 21 days in any contract year for each unrelated illness with certain benefits for 245 additional days.

H. S. S. of S. F., 21 days in any 12-month period.

Ross-Loos Medical Group, 90 days.

Permanente Foundation Hospitals, 111 days.

Therefore, their experience with reference to the amount of hospitalization will not be exactly comparable without adjustment. For this purpose the tables in the accompanying section "Duration of Hospitalization" may be found useful. The number of cases hospitalized per member per year is not affected and should be comparable, with the exception of Insured Group 2, which excluded hospitalization of less than 18 hours. Table (50) has been prepared to set forth the comparative incidence taken from the recorded experience herein reviewed.

Wide variation is immediately apparent. When the memberships are analyzed and grouped into classes, however, certain similarities appear. The membership groups may be classed as industrial and non-industrial. The difference of primary importance between the two classes is in the degree of turnover. By turnover in this sense is meant the replacing of former members with new entrants, to which may be added, in the same concept, the assumption of liability toward groups of new membership without selection by medical examination. A membership that has had the benefits of prepaid or insured medical care for a considerable period may be termed "select," as distinguished from a membership newly enrolled without medical examination. Under the circumstances obtaining at the time of the experience studied, the industrial groups were in a constant state of turnover, that is, were generally "non-select." In the non-industrial groups, the membership was more stable, and coverage was extended to few or no medically unexamined new members.

In the non-industrial class are Insured Group 1, the membership of which is largely Bank and Insurance Company employees, and H. S. S. of S. F., with membership of municipal employees. In the industrial class may be placed Insured Group 2, the membership of which were employees of a manufacturing plant, and Permanente, its membership, from which this experience is derived, being employees of Richmond Ship Yards. The membership of Ross-Loos Medical Group and California Physician's Service is comprised of groups and individuals of both classes.

California Physicians Service was in the process of expansion and increased its membership, under C. P. S. Hospital Contracts, about 10 per cent in the four-month period from April to July, a rate of about 30 per cent per year. In this respect it resembles the Industrial Groups. Furthermore its membership is largely industrial. It may, therefore, be compared to Insured Group 2, and the Permanente Group.

In comparing C. P. S. with Permanente, consideration must be given to the fact that the panel of physicians connected with C. P. S. is composed of Doctors in private practice, each maintaining his own office, and

apt to lean heavily upon the hospitals for facilities and nursing not usually available in private offices. At Permanente the physicians have access to such facilities without actually entering the patient as a hospitalized case unless bed care is imperative.

The same is true, probably to a greater extent, in the Ross-Loos Medical Groups, the clinic of which is as fully equipped as a hospital with facilities for giving complete service except to patients requiring overnight care in a hospital. From this might be expected, in an equal membership, more cases hospitalized but for a shorter average duration in C. P. S. than in Permanente or Ross-Loos. Such is found to be the experience. The average duration in C. P. S. experience was about 5.5 days, in Permanente about 7.6 and in Ross-Loos 8.2. The difference is not due to a difference in the allowed duration of any one case, which is longer in C. P. S. than in either of the others.

For the comparison of the experience of C. P. S. with that of Insured Group 2, the latter must be adjusted for the exclusion of hospitalization of less than 18 hours. Reference to Tables A and B in "Duration of Hospitalization" discloses that the exclusion of hospitalization of one day would reduce the incidence one-fifth to one-third. If an adjustment upward of one-quarter be made in the incidence of Insured Groups 2, the resulting index would be .135. This, when interpreted with reference to the relative approximate percentage of female membership, will be found to agree very closely with the experience of C. P. S.

The low incidence of Ross-Loos is partly accounted for in the discussion above. There is the further factor of low turnover. The membership of Ross-Loos is more stabilized than other industrial groups in which respect it resembles the non-industrial. The contention is that in matured groups, the standard of health is raised and the need for hospitalization lowered. This is borne out by the experience of the Ross-Loos Group which in 1939 was an incidence of .055 with an average duration of 13.2 days per surgical case and 8.3 days per medical case, and in 1944 was an incidence of .035 with an average duration for all cases of 8.2.

From these considerations it would appear that the incidence of Insured Groups 2 would be one-fourth to one-half higher if hospitalization of one day duration were included, and that the incidence of Permanente Foundation Hospitals would be somewhat higher if clinical facilities were not readily available to the physicians. From this we may conclude that in an industrial membership with a high rate of turnover or a large percentage of new entrants, the incidence of hospitalization will be about .14 per member per year under conditions of private practice. In non-industrial groups with low turnover, or an otherwise select membership, the incidence of hospitalization will be about .085 per member per year under conditions of private practice. Under conditions of clinical practice the corresponding indices would be about .11 and .06 respectively. These conclusions may be stated in another way. In a non-select membership if minor cases are hospitalized, the incidence will be about .14, if only major cases, about .11. In a select membership, if minor cases are hospitalized, the incidence will be about .085, if only major cases, about .06.

The incidence thus expressed refers to a mixed membership consisting of equal numbers of men and women. Further reference to Table (50) disclosed that where the experience has been recorded separately for male

and female exposure, the incidence of hospitalization of women is about one and one-half times that of men. Table (49) has been prepared to set forth the indices of incidence of both men and women in the various divisions indicated above.

Table 49

Number of Hospitalized Cases per Member per Year

Division	*Groups*	*Incidence*	
		Men	*Women*
Select, Private Practice	Insured Group 1		
	H. S. S. of S. F.	.068	.102
Select, Group Practice	Ross—Loos	.048	.072
Non-Select, Private Practice	Insured Group 2		
	C. P. S.	.112	.168
Non-Select, Group Practice	Permanente	.088	.132

As in other kinds of medical care, the experience relative to the hospitalization of children is too meager for reliable inference. Such evidence as is available (See Table 31) would indicate that the incidence is about equal to that of adult males.

It will be found in most exposure groups that the length of the stay in the hopsital per case varies inversely with the incidence. This appears to be due to the degree of severity of the cases hospitalized. However, there are a number of social and economic factors which may have a bearing. Particularly the lack of hospital facilities in recent years has probably had the general effect of reducing the length of stay. To whatever extent this has been true it may be classed as the effect of control directly as imposed by the management of facilities the demand for which is more than the supply, and indirectly by the difficulty of obtaining such facilities. The point being made here is that in the presence of adequate hospital facilities, the average hospital duration per case may be expected to rise unless checked by efficient supervisory control.

The accompanying Table (51) has been prepared to set forth the comparative length of stay of hospitalized cases as shown in the experience herein recorded. It becomes immediately apparent that there is no great difference in the average length of stay with reference to men and women, but for children it is only about one-half that of adults. If this be made an assumption with respect to that experience not so recorded to render the information otherwise available, the table can be filled out for Ross—Loos and Permanente.

In the construction of Table (52), the incidence was taken from Table (50). The average stay per case is the same for men and women and is taken as the average of the duration of the groups in each division. The incidence of hospitalization of children is assumed to be the same as that of employed males, and the duration one-half that of an adult. An exposure consisting of adult dependents appears to give rise to an experience about equal to that of female employees.

The results shown may be considered to correspond to a maximum duration of about 30 days in Division 1 and 3, and about 90 days in Division 2 and 4. For longer or shorter maximum durations adjustment may be made proportional to factors shown in Table E, "Duration of Hospitalization."

These considerations lead to the conclusion that the amount of expected hospitalization depends primarily upon the method of administration of medical care. A second conclusion would appear to be that in a select group, the hospital requirements will be less than in a newly enrolled

medically unexamined group. This should not be made the basis for a prediction that in a given group the demand would actually decrease. The reverse might well be the trend due to augmentation of facilities and an increasing reliance on their use.

Table 50

Comparative Incidence of Hospitalization

Experience	*Employed Male*	*Employed Female*	*Adult Dependent*	*Minor Dependent*	*All Employed Members*	*All Members*
Insured Group 1	.058	.094	---	---	.076	---
Insured Group 2	.090	.135	---	---	.108	---
C. P. S.	---	---	---	---	---	.159
H. S. S. of S. F.	---	---	.089	.063	.082	.082
Ross-Loos, 1939	.049	.071	---	---	.055	---
Ross-Loos, 1944	---	---	---	---	.035	---
Permanente	---	---	---	---	.109	---

Table 51

Comparative Duration of Hospitalization, Average Number of Days per Case

	Employed Male	*Employed Female*	*Adult Dependents*	*Minor Dependents*	*All Members*
Insured Group 1	8.8	8.2	10.6	4.1	8.4
Insured Group 2	7.8	10.7	--	--	9.2
C. P. S.	7.0	6.7	7.1	2.2	5.5
H. S. S. of S. F.	8.2	9.9	8.7	5.1	8.1
Ross-Loos, 1939	--	--	--	--	10.7*
Ross-Loos, 1944	--	--	--	--	8.2
Permanente	--	--	--	--	7.0

* Approximate.

Table 52

Average Number of Hospital Days per Member per Year

Division	Group	Incidence			Days Per Case		Average Stay (in Days) Per Member Per Year		
		Men	Women	Children	Adult	Child	Men	Women	Children
1. Select, Private Practice	Insured Group 1								
	H. S. S. of S. F.	.068	.102	.068	8.8	4.4	.60	.89	.30
2. Select, Group Practice	Ross-Loos	.048	.072	.048	9.4	4.7	.45	.68	.23
3. Non-select, Private Practice	Insured Group 2								
	C. P. S.	.112	.168	.112	8.0	4.0	.90	1.34	.45
4. Non-select, Group Practice	Permanente	.088	.132	.088	7.0	3.5	.62	.92	.31

Duration of Hospitalization

For this study there were available statistics of the "Bank of America" group, for a description of which see "Insured Groups." It is well adapted to the purpose being uncontrolled in the sense of close administrative jurisdiction, a distinction which has been discussed in the comparison of the different types of voluntary plans. However, during the exposure period studied, Feb. 1, 1943 to Nov. 1, 1945, there was an existing insufficiency of hospital accommodations, and it may be assumed that this would have had the effect of limiting the length of stay to the actual requirements.

The group included an average membership of 7,345 employed members approximately half of whom were female, 2,332 dependent adults, almost all female, and 1,420 families of children between the ages of 3 and 20 inclusive. The exact number of children could not be determined and it was assumed that there were 1.6 children per family. This assumption is substantiated to some extent by the fact that the average duration per member as shown by the resulting table agrees very closely with the average period of hospitalization as indicated in Table (3).

The results are shown in Table A. Column 1, "n," is the exact number of days hospitalized. Column 2 is the number of cases. Column 3 is the number of cases on a basis of 1,000,000 life years of exposure. Column 4 is the number of "Bed Days," Column (1) times Column (3). Column 5 is the accumulated totals of Column (4) to n-70. Column 6 is the accumulated totals of Column (3).

Reference is made to Table XIII of "Hospital Service Insurance" by Arthur Hunter and Allen B. Thompson,* based on an experience of 1,926,000 life years exposure. Table B, shows the results of that study, on a basis of 1,000,000 life years exposure. The columns are arranged in the same way as in Table A.

A general comparison of the two tables reveals that, although the average amount of hospitalization per member in Table B, .645 days, is greater than that in Table A, .550 days, the amount of hospitalization of eleven days or less and of seventy days or more under Table A, exceeds that of Table B. Some workable conclusions may be drawn as follows:

(a) Since the difference in the total hospitalization per member in the two tables, is less than 1/10 of one day per year, the tables may be said to substantiate one another, and either may be considered to be reasonable representation of the expected experience in California, and therefore,

(b) Since the tables reveal considerable variation from one another relative to certain durations of hospitalization, that in the consideration of the amount of hospitalization incident to specified maximum durations, the more conservative table with respect to that specific duration may be used.

There is little need for reliance upon the experience expressed by these tables for hospitalization of short duration, for which there is considerable other experience available, much of which is detailed in the "Discussion" of Hospitalization. However, in the consideration of incidence of hospitalization of comparative duration, the table may be found useful.

It will be noticed that the figures in Column (5) and (6) are not complete due to lack of information as to how long the number of patients appearing opposite the last "n" were actually hospitalized. In order to

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extend the tables for a complete experience, the exact period for each of these patients would have to be known, or some assumption made concerning their probable individual or combined period of hospitalization.

With this in view Table C, has been constructed as an arbitrary adjustment to Table B. The purpose was not to approximate the probable actual experience but to develop a basis for a liberal estimate of complete hospitalization. An assumption as to the duration of the hospitalization of those indicated to have been hospitalized more than 111 days was made, as shown, the duration for the final ten patients being assumed to have been for life, and to have begun at their respective quinquennial ages 10 to 55 inclusive. Their individual durations of hospitalization was then taken to be their life expectancy according to the American Experience Table of Mortality.

A similar extension, Table D, has been constructed for Table A. The figures in Column (3) opposite n-70 to n-life were found by letting the percentage of each to the total number of Column (3) cases hospitalized for n-70 or more, be the same as the corresponding percentage in Table B and C. The Column (4) in each table was then calculated by multiplying the figures in Column (3) by the day duration in Column (1). "Life" was found to be an average of 33.33 years or 12,165 days. Finally, Column (4) in both Tables C and D, was added and adjusted to produce a single factor which when divided by 1,000,000 yields the days of hospitalization per member, to be added to Column (5) in Tables A and B to adjust those columns for hospitalization of indefinite duration. The Tables A and B are, therefore, independent of the assumed extensions and any other assumption of extended duration may be applied without first correcting any of the figures in those tables.

The figures in Columns (5) of the tables represent millionths of a hospital day per member, per year. By their use the amount of hospitalization in days per member, per year for any prescribed duration can be determined.

Table E shows the results of various types of coverage according to both Tables A and B, adjusted where necessary by extensions D and C respectively. The figures in which these extensions are involved are marked (*).

Table A

(1) n	(2) Cases	(3) Cases	Per Million Life Years Exposure (4) Bed Days	(5) Col-4 Summation	(6) Col-3 Summation
1	615	18,635	18,635	18,635	18,635
2	250	7,575	15,150	33,785	26,210
3	146	4,424	13,272	47,057	30,634
4	122	3,697	14,788	61,845	34,333
5	122	3,697	18,485	80,330	38,028
6	119	3,606	21,636	101,966	41,634
7	102	3,091	21,637	123,603	44,723
8	98	2,969	23,752	147,355	47,694
9	83	2,515	22,635	169,990	30,209
10	115	3,485	34,850	204,840	53,694
11	91	2,757	30,327	325,167	56,451
12	63	1,909	22,908	258,075	58,360
13	62	1,879	24,427	282,502	60,239
14	61	1,848	25,827	308,374	62,087
15	45	1,364	20,460	328,834	63,451
16	26	788	12,608	341,442	64,239
17	28	848	14,416	355,858	65,087
18	25	758	13,644	369,502	65,845
19	15	455	8,645	370,147	66,300
20	12	365	7,280	385,427	66,664
21	18	545	11,445	396,872	67,209
22	8	242	5,324	402,196	67,451
23	2	61	1,403	405,599	67,512
24	7	212	5,008	408,687	67,724
25	5	152	3,800	412,487	67,876
26	9	273	7,098	419,585	68,149
27	7	212	5,724	425,309	68,361
28	8	242	6,776	432,085	68,603
29	4	121	3,509	435,594	68,724
30	6	182	5,460	441,054	68,906
31	0	0	0	441,054	68,906
32	2	61	1,952	443,006	68,967
33	2	61	2,013	445,019	69,028
34	2	61	2,074	447,093	69,089
35	0	0	0	447,093	69,089
36	3	91	3,276	450,369	69,180
37	0	0	0	450,369	69,180
38	1	30	1,140	451,509	69,210
39	1	30	1,170	452,679	69,240
40	4	121	4,840	457,519	69,361
41	0	0	0	457,519	69,361
42	4	121	5,082	462,601	69,482
43	1	30	1,290	463,691	69,512
44	3	91	4,004	467,895	69,503
45	2	61	2,745	470,640	69,664
46	0	0	0	470,640	69,664
47	0	0	0	470,640	69,664
48	0	0	0	470,640	69,664
49	4	121	5,929	476,569	69,785
50	4	121	6,050	482,619	69,906
51	1	30	1,530	484,149	69,936
52	0	0	0	484,149	69,936
53	0	0	0	484,149	69,936
54	1	30	1,620	485,769	69,966
55	1	30	1,650	487,419	69,996
56	3	91	5,096	492,515	70,087
57	1	30	1,710	494,225	70,117
58	0	0	0	494,225	70,117
59	1	30	1,770	495,995	70,147
60	0	0	0	495,995	70,147
61	1	30	1,830	497,825	70,177
62	0	0	0	497,825	70,177
63	1	30	1,890	499,715	70,207
64	0	0	0	499,715	70,207
65	1	30	1,950	501,665	70,237
66	1	30	1,980	503,645	70,267
67	0	0	0	503,645	70,267
68	0	0	0	503,645	70,267
69	0	0	0	503,645	70,267
70	22	667	46,690	550,335	70,934

Table B

(1) n	(2) Cases	(3) Cases	Per Million Life Years Exposure (4) Bed Days	(5) Col-4 Summation	(6) Col-3 Summation
1	22,313	11,585	11,585	11,585	11,585
2	11,547	5,996	11,992	23,577	17,581
3	7,153	3,714	11,142	34,719	21,295
4	6,748	3,503	14,012	48,731	24,798
5	6,625	3,440	17,200	65,931	28,238
6	5,929	3,078	18,468	84,399	31,316
7	5,951	3,090	21,630	106,029	34,406
8	5,097	2,647	21,176	127,205	37,053
9	4,886	2,537	22,833	150,038	39,590
10	5,711	2,965	29,650	179,688	42,555
11	5,247	2,724	29,964	209,652	45,279
12	4,679	2,429	29,148	238,800	47,708
13	4,472	2,322	30,620	268,986	50,030
14	4,487	2,330	32,620	301,606	52,360
15	3,906	2,028	30,420	332,026	54,388
16	3,018	1,567	25,072	357,098	55,955
17	2,550	1,324	22,508	379,606	57,279
18	2,092	1,086	19,548	399,154	58,365
19	1,937	1,006	19,114	418,268	59,371
20	2,052	1,065	21,300	439,568	60,436
21	2,294	1,191	25,011	464,579	61,627
22	1,034	537	11,814	476,393	62,164
23	740	385	8,855	485,248	62,549
24	609	316	7,584	492,832	62,865
25	603	313	7,825	500,657	63,178
26	506	263	6,838	507,495	63,441
27	486	252	6,804	514,299	63,693
28	557	289	8,092	522,391	63,982
29	380	197	5,713	528,104	64,179
30	353	184	5,520	533,624	64,363
31	290	150	4,650	538,274	64,513
32-45	2,328	1,209	45,232	583,506	65,722
46-60	955	496	25,675	609,181	66,218
61-70	348	180	11,814	620,995	66,398
71-81	435	226	17,719	638,714	66,624
82-90	53	28	2,357	641,071	66,652
91-111	44	23	2,210	643,281	66,675
Over 111	35	18	2,290	645,571	66,693

Table C

n	Cases Per 1,000,000	Bed Days Per 1,000,000
112-170	8	1,128
Life (12,165 Days)	10	121,650
Total		122,778
Factor		2,290
Total Less Factor		120,488

Table D

n	Cases Per 1,000,000	Bed Days Per 1,000,000
70	253	17,710
71- 81	318	24,158
82- 90	39	3,354
91-111	32	3,232
112-170	11	1,551
Life (12,165 Days)	14	170,310
Total		220,315
Factor		46,690
Total Less Factor		174,625

Table E

Period Covered	Bed Days Per Member Table A	Per Year Table B	Period Covered	Bed Days Per Member Table A	Per Year Table B
14 Days	.432	.502	After 14 Days	*.293	*.264
21 Days	.475	.571	After 21 Days	*.250	*.195
30 Days	.502	.604	After 30 Days	*.223	*.165
60 Days	.542	.638	After 1 Year	*.166	*.120
90 Days	*.554	.645			
One Year	*.559	*.646			
Complete	*.725	*.766			

Cost

Of the four divisions into which medical care has been divided for analysis, "Laboratory and X-ray" has already been treated from a standpoint of cost. "Medical," "Surgical," and "Hospitalization" have been treated from a standpoint of incidence and "use." It is the purpose of this section to apply to unit services such unit costs as may appear to be prevalent in present practice with a view to determining an approximate average cost, in each type of administrative practice, of the demand for service.

The cost of a unit of service will be found to vary greatly and to depend upon several factors the most important of which are (1) the facility with which the patient can be brought to the source of service or vice versa; (2) the degree of adequacy of hospital, laboratory and other facilities present at the point required; (3) the extent to which such service can be delegated to assistants and nurses; (4) the efficiency of the use of facilities in the sense of their constant or intermittent use; and (5) the variation in the foundation, overhead, and administrative costs per unit service. To these might be added the degree of standardization of procedure a factor which would apply in a well organized "system" to the cost already determined by the other five. It is not possible on the basis of the experience at hand to evaluate all of these factors even as they exist in the Types or Plans of medical care studied. Nor would it be of more than academic value to do so inasmuch as any newly devised system, as well as the evolution of Plans now operative, would present new complications requiring specific reconsideration.

There is, however, an arbitrary designation of unit values in use by C. P. S. and H. S. S. of S. F., the unit systems of which fix standard monetary values for unit services, as rendered by physicians, under the conditions and in the general circumstances, relative to the five factors mentioned above, obtaining in their present mode of practice. If these values be applied to the average experience previously detailed the result will be the cost of such conditional presumed experience under similar circumstances.

The actual costs of unit services in group clinical or hospital practice as experienced by Ross-Loos Medical Group and Permanente Foundation Hospitals are not available. They could be determined only by elaborate accounting beyond the practical administrative requirements of such organizations. As is the policy in the administration of Insured Groups, the experienced overall cost of contractual service rendered may be made the basis for adjustment in the rates charged, a change in the amount or scope of benefits offered, or the institution of more effective control. The monetary cost of a unit of service rendered in a clinic under group practice is probably lower than the cost of a similar service

rendered at present by private physicians or laboratories. An explanation of the difference may be sought in the five cost factors mentioned above.

The cost to the carrier of Insured Plans is of little relative importance in a discussion of cost of service unless the amounts allowed under the contract approximate the full actual charges. The amounts allowed in the contract of Insured Group 1 approach the actual cost, with reference to Surgical and Special Hospital Facilities.

There is a wide range of charges for a unit service in Private Practice. Certain average costs are indicated in the section "Type I Medical Care."

The schedules of unit values of C. P. S. and H. S. S. of S. F. differ with respect to certain services, but in general are closely commensurate. Where such unit values are assigned to services in this discussion they will be approximately those of C. P. S. which, with minor variations, are also those of H. S. S. of S. F.

In the valuation of "Doctor's Calls" it is necessary to determine as nearly as possible the average value of a single "call." In the experience of C. P. S. during 1940 and 1941, the average number of calls was found to be 5.96 per member per year and the average number of medical units per member .62 per month or 7.44 per year. This would indicate about 1.27 units per call. Since the par value of a unit was $2.50, the cost per call was $3.18. In the experience during the four months of 1945 shown in Table (16), there were 24,027 visits with a total cost of $79,105, an average of $3.33 per call. In the experience of H. S. S. of S. F. for the year ending Sept. 30, 1943 (See Table 25) there were 62,353 calls with a total cost including "special services" of $214,207.47, an average cost for service per call of $3.44. In the experience of the same system for the year ending Sept. 30, 1944, there were 68,347 calls with a total cost of $218,353.83, an average of $3.19 per call. These results agree very closely with the average fees in private practice as shown in Table (2). There the average fee for a routine office call appears to be about $3.16, and if city and county home calls are included, about $3.40. The extra charges for examinations and "first calls" can be thought of as reflecting repayment to the physician of amounts expended for laboratory and X-ray procedures required. The conclusion may be drawn that the average cost of a "doctor's call" is about $3.20.

On that basis, with reference to the conclusions arrived at in the discussion of "medical," the costs per life year for physician's medical service would be:

Male, 8 calls per year at $3.20	$25.60
Female, 12 calls per year at $3.20	38.40
Child, 5 calls per year at $3.20	16.00

In the discussion of "Laboratory and X-ray" the average cost of those services per person per year was found to be $5.29. This cost pertains to non-hospitalized cases, and is approximately the same for male lives as for female lives.

There is no experience available from which the cost of these services for children might have been determined. Since the cost of other physician's services per child appears to be about half that of an adult, the cost of laboratory and X-ray can be assumed to follow the same relation. On that basis the cost per child per year would be about $2.65.

In the discussion of "Incidence of Surgery" the conclusion was reached that there is an expected average incidence of .12 surgical cases per male life year and .17 surgical per female life year. The only available experience in which the incidence of surgery among children is contained is that of Insured Group 1. There the indication is that, from all causes, it is about the same as for male employees.

The average cost of a surgical case from these sources is given below.

Surgical Cost per Case

	Male Employee	*Female Employee*	*Child*	*Adult Dependent*	*All Employees*	*All Members*
Insured Group 1	$54.98	$68.75	$33.67	$66.60*	$62.94	$60.70**
C. P. S.	44.41	53.63	39.80	71.32	49.56	51.95
H. S. S. of S. F.	----	----	----	----	----	42.70

* On the basis of a reduced "schedule of operations."
** Partly on the basis of a reduced "schedule of operations."

These costs include only the fees of the surgeon and charges for consultants, assistants, and anaesthetists. Operations in connection with maternity, pregnancy, or miscarriage are excluded.

The most complete data is that relative to the experience of California Physicians Service, and it is reasonable to assume that the costs per case are fairly representative of the costs generally to be expected in California medical practice. In that experience, there is a wide difference in the cost per case for employed women and adult dependents all of whom were spouses, undoubtedly a large majority female. The indication is, therefore, that the average surgical cost per case of unemployed married women is greater than that of employed women. If the incidence of surgery be applied to each cost per case an upper and lower limit of surgical cost per female life per year consistent with this experience will be derived. The actual expectation will be somewhere between these limits, depending on the percentage that each class bears to the total female membership.

On this basis the expectation of surgical cost may be stated as follows:

Participant	*Incidence of Surgery Per Year*	*Cost Per Case*	*Cost Per Member Per Year*
Employed Men	.12	$44.41	$5.33
Employed Women	.17	53.63	9.12
Unemployed Married Women	.17	71.32	12.12
Child	.12	39.80	4.78

The cost of hospitalization is divided into two parts which are (1) "bedside care," and (2) "special hospital services." Bedside care refers to room and board, nursing service, and general care of the patient. Special hospital services include anaesthetic, laboratory examinations, X-ray examinations, use of operating room, and use of other special equipment or service entailing an extra charge. The two are here treated separately because the cost of bedside care is a function of the time spent in the hospital and is directly proportional to the number of hospital days, whereas the use of special hospital services appears to be a function of the "case," and independent of the duration of hospital stay.

In some of the experience presented herein a statistical division has been made with respect to the two kinds of hospital cost, and in some it has been combined under the heading of "cost of hospitalization." Table (53), presents the segregation where available.

It will be seen with reference to Table (53), that the cost of bedside care is fairly regular, any slight variation probably being due to the degree of privacy required by the patient.

A wide variation is apparent with respect to cost of special hospital services. These coasts in Insured Group 1 probably reflect a large amount of service which in C. P. S. would have been included in "Laboratory and X-ray," since much of such service can be performed in or out of the hospital, or in comparison with Ross-Loos Medical Group which would in all probability perform as much of such service in its own clinic as practicable. The greater cost per hospital day for "all members" in C. P. S. than for "all members" of H. S. S. of S. F. may be accounted for by the fact that such services are limited in the Health Service System of San Francisco and the total cost per day is lower accordingly. This is particularly obvious in the costs for children.

In C. P. S. the cost of bedside care of children is slightly higher than for adults, and although the cost of special services is a little lower, the total cost per day is much higher. This is because the cost of special services per case is divided among fewer days.

The costs of C. P. S. are more appropriate to this study than any others at hand. The normal cost of bedside care appears to be about $7.00 per day, for adult patients. In the experience of H. S. S. of S. F. bedside care of children is more costly than that of adults, substantiating to some extent the higher C. P. S. cost for children of $7.65 per day.

The cost of special hospital services as shown in the experience of C. P. S. may be extended to general application. Its practice in this respect may be considered to be standard, and the benefits are unlimited. The costs need no adjustment and, considered as approximations, may be applied as they are. There being no significant difference between the cost for adult dependents (spouses) and the cost for female employees, the latter may be taken as the average for all female patients.

Table 54 sets forth the results of analysis of Hospital Costs. With respect to new memberships, only those for the enrollment of which a medical examination is required with a proviso that preexisting conditions will not be treated can be considered "select." A membership enrolled as a group without medical examination is "non-select."

The costs arrived at in this discussion have been derived by the application of average unit costs in present "fee for service" practice as nearly as could be determined from the data at hand, to the incidence of demand in some cases based upon average experience and in some cases based upon "expected" experience under certain defined conditions. As such they are to be considered more in the nature of monetary measures of the statistical results than as cost estimates. It was stated in the Introduction that any "system" of medical care reaches a balance of the interrelation of Facilities, Incidence, and Cost. Within the single element of cost of unit service there are many factors, five of which were specially mentioned in the beginning of this discussion, which would have a greater effect upon a projected cost estimate than can be expressed by averages thus obtained. Once such an equilibrium has been reached, as exemplified by individual insured and prepaid Plans operative for a considerable period, a remarkable consistency of experience and cost from year to year, and even from season to season, develops. An attempt to generalize such experience and to extend such consistency toward other membership groups is apt to result in greater variation than expected. This is demon-

strated by Insured Groups which under similar contracts, the same administration, and in contiguous territories, exhibit wide differences in experience and cost. The same is true of medical care in different regions under the same Prepaid Plan.

It follows that in the contemplation of a Prepaid Medical Plan, or medical care of any mode of operation, due attention should be given to the upper and lower limits of experience incidence, demand, and cost, as well as to averages.

Table 53

Cost of Hospitalization

	Insured Group 1	*C. P. S.*	*H. S. S. of S. F.*	*Ross-Loos*
Male Employees:				
Bedside Care per day	----	$6.98	----	----
Special Facilities per case	$51.05	12.24	----	----
Total Cost per day	5.80	8.72	----	----
Female Employees:				
Bedside Care per day	----	7.01	----	----
Special Facilities per case	40.66	15.46	----	----
Total Cost per day	4.94	9.30	----	----
Adult Dependents:				
Bedside Care per day	----	7.25	----	----
Special Facilities per case	----	14.79	----	----
Total per day	----	9.34	$9.31	----
Children:				
Bedside Care per day	----	7.65	----	----
Special Facilities per case	----	11.25	----	----
Total Cost per day	----	12.70	9.68	----
All Employees:				
Bedside Care per day	----	----	----	----
Special Facilities per case	45.86	----	----	----
Total Cost per day	5.41	----	9.57	----
All Members:				
Bedside Care per day	----	7.45	----	----
Special Facilities per case	----	13.94	----	----
Total Cost per day	----	9.97	9.45	$9.00

Table 54

Cost of Hospitalization

Member		*Cases Per Year Per Member*	*Hospital Days Per Year Per Member*	*Cost of Special Service Per Case*	*Cost of Bedside Care Per Day*	*Cost of Special Service Per Member Per Year*	*Cost Bedside Care Per Member Per Year*	*Total Hospital Cost Per Member Per Year*
Class 1.	Male Employee	.068	.60	$12.24	$7.00	$.83	$4.20	$5.03
	Female Employee	.102	.89	15.46	7.00	1.58	6.23	7.81
	Child Employee	.068	.34	11.26	7.65	.76	2.60	3.36
Class 2.	Male Employee	.048	.45	12.24	7.00	.59	3.36	3.85
	Female Employee	.072	.68	15.46	7.00	1.11	4.76	5.87
	Child Employee	.048	.23	11.25	7.65	.54	1.76	2.30
Class 3.	Male Employee	.112	.90	12.24	7.00	1.37	6.30	7.67
	Female Employee	.168	1.34	15.46	7.00	2.60	9.38	11.98
	Child Employee	.112	.45	11.25	7.65	1.26	3.44	4.70
Class 4.	Male Employee	.088	.62	12.24	7.00	1.08	4.34	5.42
	Female Employee	.132	.92	15.46	7.00	2.04	6.44	8.48
	Child Employee	.088	.31	11.25	7.65	.99	2.37	3.36

Class 1—is Select, Private Practice.
Class 2—is Select, Group Practice.
Class 3—is Non-select, Private Practice.
Class 4—is Non-select, Group Practice.

EXHIBIT A

BANK OF AMERICA

Employees Group Hospital and Surgical Plan

If an insured employee is confined to a legally incorporated hospital as a result of disability caused by a non-occupational accident or any sickness not covered by Workmen's Compensation Law, he or she will be entitled to the following benefits:

(a) Daily benefit of Five Dollars ($5.00) for each day such employee is confined, but not for longer than ten weeks during any consecutive twelve months period. Confinement in a hospital shall be construed to mean confinement for at least one night.

(b) Reimbursement for Special Hospital Services, actually charged by the hospital, not to exceed Thirty Dollars ($30.00) in any twelve consecutive months. Such services shall include anesthetic, laboratory examinations, use of operating room, and X-ray examinations. X-ray or other treatments shall not be considered Hospital Services under the plan.

* On October 1, 1939, the plan was extended, to cover X-ray examinations performed outside of the hospital up to a maximum of $15.00 for any one disability. On February 1, 1943, the plan was further extended to cover laboratory examinations performed outside of the hospital up to a maximum of $15.00 for any one disability. On October 1, 1944, the plan was again extended to cover the cost of such Hospital Services including medicines, drugs and dressings necessarily furnished while the employee is in the hospital up to a limit of $150.00 for all items combined. These liberalizations were made because of the favorable experience under the plan and will be continued so long as the claim experience remains reasonable.

(c) If the accidental injury or sickness necessitates ambulance transportation to or from the hospital, the Insurance Company will pay the cost of such transportation up to $5.00 per trip. Not more than two such trips will be allowed during any one disability.

(d) The plan also provides that if by reason of accidental injury, which does not arise from and in the course of employment, the employee is physically unable to communicate with friends, the Insurance Company will defray all expenses, not to exceed Fifty Dollars ($50.00) necessary to put the employee in communication with and in the care of friends.

Premium Payments

The cost of hospital benefits described above is .75 per month for each insured employee payable by salary deduction. An employee may select the hospital benefits set forth above without applying for surgical benefits described below.

Surgical Benefits

Any insured employee requiring a surgical operation, due to non-occupational accident or any sickness not covered by Workmen's Compensation Law, will be entitled to reimbursement for surgical fees actually charged by a legally qualified surgeon but not to exceed the maximum amount shown in the fee schedule of operations on subsequent pages of this booklet.

If two or more surgical operations are performed upon an employee at any one time or during any one continuous period of disability, whether from one or more causes, or during successive periods of disability due to the same or related cause or causes, the total amount of reimbursement hereunder for all such operations shall not exceed Two Hundred Twenty-five Dollars ($225.00), the maximum Surgical Operation Benefits.

The Company reserves the right to determine the amount of reimbursement for the actual surgical fee charged for any surgical operation performed which is not itemized in the Schedule of Operations. An operation of equivalent gravity and severity will be used as a basis for the Company's settlement.

Premium Payments

The cost of surgical benefits described above is $.50 per month, in addition to premium paid for hospital benefits, for each insured employee payable by salary deduction.

Benefits As They Apply to Dependents

Hospital and Surgical Benefits may be extended to the wives and children, and husbands in the case of married female employees, of all employees who have such dependents and who are insured under the plan themselves. The following regulations apply to benefits for dependents:

General Rules

(a) Dependents of new employees shall be wives under age forty-five, husbands age fifty and children between three and twenty years of age inclusive. The children must be single and gainfully employed.

(b) No dependent can be insured unless the employee is similarly insured.

(c) Insurance must cover all eligible dependents. A dependent child under three years of age becomes eligible upon attaining such age. However, the Personnel Relations Department must be notified within thirty days from the date the child reaches his third birthday, so that arrangements may be made to have the child insured. If application is made subsequent to the thirty day period evidence of the child's insurability is required.

(d) Insurance on dependent children automatically cease upon attaining age twenty-one or in event of marriage or entering gainful employment prior to age twenty-one. The Personnel Relations Department should be notified of any such change.

(e) Except as outlined below, hospital benefits will be the same amount for the spouse as for the employee. Surgical Benefits will, however, be two-thirds of the schedule effective for employees. The hospital benefits on children will be $4.00 per day * instead of $5.00 as on adults. The surgical benefits on children will be the same as for adult dependents, viz., two-thirds of the schedule for employees.

(f) If the employee has hospital benefits only, his dependents may have only hospital benefits. If he has both hospital and surgical benefits, the dependents must take similar coverage.

Hospital Benefits

Insured spouses will be covered for the same hospital benefits as described for employees, in paragraphs (a), (b) and (c) on page 3 of this booklet. Benefits for children will be the same except that the daily hospital rate will be $4.00 * and the Special Hospital Services will be limited to $20.00.*

* October 1, 1944 the plan was extended to provide: (1) a daily hospital benefit of $5.00 instead of $4.00 for child dependents; and, (2) a maximum payment of $60.00 for Special Hospital Services for insured spouses and children; and, (3) payment for medicines, drugs, and dressings as Special Hospital Services. X-ray examinations and laboratory examinations performed outside of the hospital will each be covered up to $15.00 for any one disability for dependents as well as employees. These liberalizations were made because of the favorable experience under the plan and will be continued to so long as the claim experience remains reasonable.

The cost of Hospital Benefits for dependents is $1.00 per month for each adult dependent and $.45 per month for child dependents. All the eligible children in the family are covered by the one payment of $.45 per month.

Surgical Benefits

An insured dependent, either adult or child, will be subject to the rules and regulations governing Surgical Benefits for employees under the plan, as set forth on page 4 of this booklet, except that the maximum amount payable for any surgical operation for a dependent will be two-thirds of the amount shown in the schedule.

The cost of Surgical Benefits is $.75 per month for adult dependents and $.55 per month for all eligible children.

Aggregate Benefits for Dependents

Hospital Insurance may be terminated by the Insurance Company on any insured dependent who has received $1,000.00 of Hospital Benefits and Surgical Insurance may be terminated on any insured dependent who has received $450.00 of such benefits.

The Plan Does Not Provide Benefits on Account of:

(a) Injury sustained or sickness contracted while the employee is in military or naval service in time of war; (b) Injury sustained or sickness contracted while the employee is north of sixtieth parallel of latitude, in the Panama Canal Zone or the insular possessions of the United States, or surgeon; (d) Maternity, pregnancy, or miscarriage; (e) Accidental bodily injury which arises from and in the course of employment or any sickness for which employee is paid benefits under any Workmen's Compensation law or act; (f) Dental service of any kind except surgical removal of impacted wisdom teeth; or (g) Insanity of a dependent.

EXHIBIT B

ADEL PRECISION PRODUCTS CORP.

Employees Group Hospital and Surgical Benefits Plan

Employee's Hospital Benefits

The Daily Hospital Benefit as shown in the outline of the plan will be paid in the event an insured employee is confined to a lawfully operating hospital for eighteen hours or more as a result of disability caused by a non-occupational accident, or any sickness not covered by a Workmen's Compensation Law. This benefit will be paid for

a period not exceeding 31 days during any one disability except that if hospital confinement is due to pregnancy, the benefit is payable for not more than fourteen days.

In addition to the Daily Hospital Benefit, an insured employee who is entitled to the Daily Hospital Benefit, will be allowed up to Twenty-Five Dollars ($25.00) for Special Hospital Services actually charged by the hospital. Such Hospital Services include anesthesia, laboratory examinations, X-ray examinations, and operating room fees. X-ray treatments or other treatments are not included under this provision.

Successive periods of hospital confinement shall be considered a single period of confinement unless due to different causes.

Surgical Benefits

The Surgical Benefits for an insured employee or an insured dependent are provided under a specified fee schedule as shown in the Schedule of Operations (See Pages 16 and 17). For operations not listed, appropriate fees will be paid according to their equivalent gravity and severity.

A maximum of One Hundred Fifty Dollars ($150.00) will be allowed insured employees or insured dependents for any two or more operations at any one time or during any one disability. Surgical Benefits are payable in addition to any Hospital Benefits to which the insured employee or insured dependent may be entitled.

Dependents' Hospital Benefits

The Daily Hospital Benefits of $5.00 per day will be paid to the employee in the event an insured dependent is confined to a lawfully operating hospital for reasons other than pregnancy for eighteen hours or more. This benefit will be paid for a period not exceeding 31 days during any one disability. In addition to the Daily Hospital Benefit, the employee will be allowed up to Twenty-Five Dollars ($25.00) for Special Hospital Services actually charged by the hospital. Such Hospital Services include: Anesthesia, laboratory examinations, X-ray examination and operating room fees. X-ray treatments or other treatments are not included under this provision.

If an employee's wife who has been continuously insured for nine months, is confined to a hospital by reason of pregnancy, the employee will be allowed $5.00 a day for no more than ten days hospitalization.

EXHIBIT C

CALIFORNIA PHYSICIANS SERVICE

Terms and Conditions of Service

Article 1. Prerequisites of Service

(a) In the event of illness or injury each member may select any doctor of medicine who is a professional member of C. P. S. When first applying for professional service, each member must notify such C. P. S. professional member that he is a C. P. S. beneficiary or family member. Failure to select a professional member or promptly to notify him of membership in C. P. S. shall each be conclusively deemed to be a waiver of all benefits hereunder.

(b) Members traveling or temporarily outside the State of California and in immediate need of any of the professional services provided herein (due to sudden emergency), are entitled to reimbursement of expenses for such services rendered by any doctor of medicine up to but not exceeding the sum which C. P. S. would have paid to a professional member for like service rendered by him in the same month.

(c) All medical and surgical services included herein are limited to a period not to exceed one (1) year for any one illness or injury (including any and all related complications).

(d) None of the services included herein are available if there is any default or delinquency in payment of monthly dues.

Article 2. Services Included

(a) *Medical Services Provided for Beneficiary Member Only:* The term "medical services" as used in the Agreement includes such non-surgical professional services as the Beneficiary Member may, as a consequence of illness or injury require.

The obligation of C. P. S. to provide "medical services" hereunder is limited to the extent stated for the following services:

(1) Each chronic ailment or condition shall receive necessary care for a maximum period of three (3) months from and after the date of the third visit by or to a professional member for each chronic ailment or condition.

(2) Professional services with respect to childbirth are excluded until the Beneficiary Member has been a C. P. S. beneficiary member for at least ten (10) successive months.

(b) *Surgical Services Provided for Beneficiary Member and Family Member:* The term "surgical services" as used in the Agreement includes all operations involving cutting or incision (including care of fractures and dislocations), if necessary for the treatment of an illness or injury.

In addition, the term "surgical services," as used in this Agreement, includes, if and while the member is a registered bed patient in a hospital, the following:

(1) Such professional radiological (X-ray) services as may be necessary to establish diagnosis, and

(2) Ordinary clinical laboratory services as follows: Urinalysis, complete blood count, coagulation time and smears.

(c) *Hospital Care Provided for Beneficiary Member and Family Members:* The term "hospital care" as used in the Agreement is subject to each of the following conditions:

(1) "Hospital Care" as used herein, means:

(i) Care in room of three or more beds;
(ii) Meals and service of dietitian;
(iii) General nursing care;
(iv) Use of operating room, including surgical and anaesthetic supplies;
(v) Use of cystoscopic room and supplies;
(vi) Routine splints, casts and dressings;
(vii) Drugs and medications up to an amount not in excess of $3.50 per hospital admission.

(2) The obligation of C. P. S. to provide hospital care, as shown defined, is limited to a period of not in excess of twenty-one (21) days during each membership year for each particular physical disability arising from a separate and distinct cause. Hospital care will be provided only while the member is necessarily confined in a hospital as a registered bed patient for the treatment of an illness or injury, and under no conditions for a rest cure or for the purpose of diagnosis.

(3) In conditions necessitating hospitalization beyond twenty-one (21) days, C.P.S. will reimburse the costs of hospital care as above defined in an amount not to exceed fifty (50) per cent of such cost for a maximum period of not to exceed three hundred and forty-five (345) days immediately following said twenty-one (21) day period.

(4) C.P.S. will defray costs of hospital emergency room charges for treatment of accidental injuries, provided use of emergency room occurs within twenty-four (24) hours following time of accident.

(5) Hospital care for childbirth will be provided under the following conditions:

(i) The member must be in a dues-paying two-person or three or more person family, and
(ii) The maximum cost to C.P.S. shall be fifty ($50) dollars in each twelve months' period, and
(iii) The member must have been a member in good standing for at least then at ten (10) consecutive months immediately preceding her need for such hospital care.

(6) C.P.S. is not responsible or liable to any member if hospitalization is unavailable as a result of epidemic, public disaster or other causes or conditions beyond its control.

(7) Members traveling or temporarily outside of the State of California are entitled to reimbursements for expenses of hospital care, subject to the conditions above set forth limiting such care.

Article 3. Services Excluded

(a) The term "Medical Services" as used in the Agreement does not include the following which are hereby excluded from the benefits of the Agreement:

(1) The cost of the first two visits by or to a professional member with respect to medical services for any one illness or injury, regardless of where said visits may occur:

(2) Eye refactions, physical therapy, cold shots;

(b) The term "Surgical Services" as used in the Agreement does not include the following which are hereby excluded from the benefits of the Agreement:

(1) Professional services with respect to childbirth (except that caesarian sections are included).

(2) Any professional service not expressly included in the definition of "Surgical Services" herein above set forth.

(c) The term "Hospital Care" as used in the Agreement does not include the following which are hereby excluded from the benefits of the Agreement: Hospitalization for pulmonary tuberculosis (after diagnosis), quarantinable diseases.

(d) Each of the terms "Medical Services," and "Surgical Services" and "Hospital Care" do not include the following which are hereby excluded from the benefits of the Agreement:

(1) Injuries or diseases for which the member is entitled to receive disability benefits or compensation or care under any Workmen's Compensation or Employers' Liability Law;

(2) Services incidence to the treatment of diseases and injuries of the jaw and their dependent tissues which customarily are performed by dentists.

EXHIBIT D

HEALTH SERVICE SYSTEM OF SAN FRANCISCO, 1942-1943

Medical Coverage and Membership Rates

The following is a reproduction of a circular of information issued to members of the Health Service System during the year under survey.

This pamphlet states the medical coverage of the System, the extent and limitation of benefits, and rates of contribution.

Membership rates as listed in the folder were in effect during the last ten months of the year (December 1942-September 1943). During the first two months of the year (October-November 1942), subscribers who now contribute $2.80 per month paid $2.50, and those who now contribute $1.80 per month (minor dependents), paid $1.50.

Choice of Doctors

From the list of accepted Staff Members, who have agreed to abide by the rules and regulations of the Health Service System, the subscriber may choose any Doctor of Medicine who is willing to treat him. When necessary, subscribers or their attending physicians may request the Medical Director to furnish a Consultant from the lists made available by the Medical Director. Any legally qualified Doctor of Medicine whose name does not appear on this list may have his name included by signing an agreement to abide by the rules and regulations adopted by this Board. Consent of the Medical Director must be secured before a patient is referred from one professional staff member to another. No patient will be rendered service by more than one doctor in any month without consent of the Medical Director.

X-ray and Laboratory Benefits Limited

X-ray examinations to the value of $10.00 and laboratory tests to the value of $5.00 are given to patients *while not in the hospital*, and are limited respectively to service for any one condition, illness or injury. After a twelve-month period has elapsed, the service of either or both may be extended, upon approval of the Medical Director, to cover a new condition illness or injury.

The liability of the Health Service System is limited to a total of five necessary office visits per month, irrespective of the number of doctors visited. Home visits or hospital visits are only limited to necessary calls.

Illnesses and Conditions Not Covered

Treatment will not be given for mental, alcoholic and drug addiction diseases, illnesses arising out of or induced by intoxication, or drug addiction of the patient, or in cases of attempted suicide or where care is provided under the Workmen's Compensation Act. No minor dependent is entitled to a tonsillectomy or adenoidectomy. No dependent or independent beneficiary is entitled to obstetrical services or services for complications of pregnancy.

Illnesses Partially Covered

A women member who is a municipal employee is entitled to the obstetrical services of a physician at any time, but must pay for hospitalization.

Preventive inoculations and vacinations will be given but the patient must supply the vaccines, toxins, et cetera used.

Hospital Care Provided

When necessary and prescribed by a physician on the professional staff and approved by the Medical Director, a patient shall be hospitalized. The Health Service System will be responsible for the bills therefore for a period of not more than twenty-one (21) days in any twelve month period for adult subscribers, and for a period of not more than ten (10) days in any twelve month period for minor dependent subscribers.

The hospital Service provided by the Health Service System will be a ward bed, meals, special diet, general nursing care, floor supply of drugs, dressings, laboratory and tissue examinations, basal metabolic rate determination, electro-cardiographs, blood typing for transfusions, physiotherapy not to exceed $10.00 in selling value, use of operating room, administration of anesthetic, plaster casts, ordinary splints, intravenous solutions.

While in the hospital during the 21 day period covered by the Health Service the patient shall be entitled, without charge, to the professional services of a roentgemologist and use of all hospital X-ray equipment and services, technician's services and facilities including films.

What Patient Must Pay For If Used

The following services if given the patient must be paid for by him: Use of operating room for extraction of teeth or dental care, dental X-ray: the use of special splints for which a rental charge is made: those drugs and medicines other than the floor supply, for which the hospital makes an additional charge to the patient: an oxygen tent or administration of oxygen therapy: the blood of a donor in blood transfusion; the use of radium, deep X-ray therapy: crutches or the use of crutches if the hospital makes a charge therefore: allergic tests, biologic tests, and orthopaedic appliances.

What Hospitalization Is Not Provided

Hospitalization is not provided for obstetrics or complications of pregnancy, venereal diseases, dental care, alcoholism, drug addiction, injuries or illness arising out of or induced by alcoholism or drug addiction, excetable nervous and mental diseases, contagious diseases quarantinable by law, illnesses or injuries resulting from attempted suicide, injuries or illnesses where the patient is entitled to care under the Workmen's Compensation Act, sanitarium treatment or care of tuberculosis, rest home or sanitarium care, other cases not admissible to an ordinary hospital. Hospitalization will not be provided for the sole purpose of diagnosis of ambulatory cases.

Private Rooms

Patients may have private room in the hospital by paying the difference between the regular ward rate and the rate charged by the hospital for the room desired.

Physiotherapy

When ordered by the attending physician, patients will be given physiotherapy treatments without charge at the Physiotherapy Department of the Health Service System only. The department is located in Room 305, Marshall Square Building, 1182 Market Street (Orpheum Theater Building). Hours are from 9 A.M. to 6 P.M. Monday through Friday, and 9 A.M. to 1 P.M. Saturdays.

Ambulance Service

Ambulance service from within the boundaries of the City and County to the hospital will be provided.

Bills for Which System Not Responsible

The Health Service System will not be responsible for any payment to doctors or hospitals who will not join the System and by rejecting the compensation schedule and rules and regulations refuse to cooperate with the city employees. The Health Service System will not be responsible for the cost of hospitalization where the member is hospitalized by a doctor not on the professional staff.

Sick Leave Report

Sick leave reports will be furnished by attending physician without charge to members of the System.

Special Nurses

Special nurses are not provided by the Health Service System.

Prescriptions

All prescriptions for medicine must be in writing and the patient must be allowed to choose his own druggist. The Health Service System does not pay for medicine.

By special arrangement with the Northern California Retail Druggists' Association, Ltd., many drug stores will give a discount on prescriptions to members of the Health Service System who show their card of membership. This applies only to medicines.

Dependents

In order to be eligible for dependent membership, a person must be wholly dependent on others for support and 50 per cent of the dependency must be on the city employee member of the Health Service System.

Dependents seeking admission to the System must submit to a medical examination. Any physical defect or pathological condition then present shall be corrected before the dependent is admitted, or such defect or condition, *whether or not found on examination*, will not be treated by the System.

No minor dependent will be admitted until attaining the age of one year.

The charge for all minor dependents shall be $1.80 each per month and all admissible minor dependents must be enrolled if any one entered in the System.

Service to dependents and to independent beneficiaries will be limited to one year for any one condition or injury.

No minor dependent is entitled to a tonsillectomy or adenoidectomy.

No adult dependent or independent beneficiary is entitled to obstetrical service for complications of pregnancy.

EXHIBIT E

Permanente Foundation Hospital
Outline of a Health Plan for Employees of the Richmond Shipyards

Coverage

Medical, surgical and hospital care and attention including necessary prescriptions and diagnostic services for diseases and also for accidents occurring away from work (accidents arising out of and in the course of employment are already covered under the Workmen's Compensation Act).

A. *Hospital Cases*

(1) Room and board for a period up to 111 days for any one disease or injury.

(2) Use of operating room, anaesthetics, drugs, dressings, X-ray and laboratory services, medicines, physiotherapy, blood transfusions, and floor nursing or private nursing, as required.

B. *Surgical Operation*

Whether at hospital or home.

C. *Doctor Visits*

Whether at hospital or home in non-surgical cases and for pre- and post-operative care.

D. *Diagnostic Services*

The Health Plan provides for X-rays and laboratory services for diagnostic purposes including basal metabolism, electrocardiograms, urinalysis, blood count and blood chemistries.

E. *Ambulance Service*

Ambulance service when necessary to or from the hospital within a radius of thirty miles from Richmond or from the Foundation Hospital in Oakland.

F. *Emergency Treatment*

Emergency treatment rendered at any other place than at the hospital named in this plan is included but the Foundation Hospital must be notified of such treatment as soon as possible. The cost of such emergency treatment is limited to $100 unless a larger amount is specifically authorized.

G. *Weekly Cost*

Each employee fifty (50¢) cents.

The weekly cost will be deducted from your pay by your employer when authorized by you.

Arrangements have been made to keep the Health Plan in effect for Richmond Shipyard workers when they are temporarily off the pay roll because of disability, vacation, or authorized leave of absence up to three weeks following the Saturday of the week in which the last Health Plan deduction was made. If they return within the three weeks period, a deduction covering the dues in arrears will be made from their first pay check. The coverage will terminate on the Saturday (11:59) P.M. of the third week following the last Health Plan deductions, unless individual payments are made to the Permanente Field Hospital. (It should be noted that this arrangement does not apply to employees whose employment terminates.)

H. *Termination of Coverage*

Coverage under the Health Plan terminates at 11:59 P.M. the Saturday of the week in which employment terminates.

How the Plan Operates

Except in Emergency—Services must be applied for at the First Aid Station in each of the yards or at the Permanente Field Hospital at Cutting Boulevard and Fourteenth Street, Richmond, or at the Permanente Foundation Hospital at Broadway and MacArthur Boulevard, Oakland. In the event of an emergency the Permanente Foundation Hospital at Broadway and MacArthur Boulevard should be notified immediately, and the patient should report to the hospital as soon as possible. The Telephone Number is HUmboldt 5720—Ask for Emergency Desk.

Services Not Included

Chronic illnesses for which a subscriber has had medical advice or treatment within one year preceding his subscription date, are not included, but emergency treatment for acute stages of chronic illnesses is included even though the subscriber has had advice or treatment within the year preceding his subscription date. Injuries and illnesses which occur after the date of employment but before subscription to the plan are not covered.

The Plan does not cover—dental services or dentures, afflictions or diseases which become epidemic or which are subject to quarantine including tuberculosis, artificial limbs, childbirth, pregnancy and miscarriage, glasses, glass eyes and injuries and illnesses resulting from acts of the public enemy. (Bombing, invasion, etc.) Vitamins and Hormones will be furnished at cost. Insulin for treatment of Diabetes will be furnished for a period of 30 days.

Care for insanity will be given until the employee may be removed to an institution, but in no event will such care be given for more than thirty days.

In the event any employee is injured by any third person who is thereby liable to such employee for the expenses of medical treatment and hospitalization, and pursuant to this agreement the employee is treated for said injury, then the employee shall be responsible to Doctor for the reasonable value of said treatment, and Doctor shall be subrogated to all of the employee's rights of recovery for the value of said treatment. It is understood, however, that the employee shall not be liable to Doctor for payment for treatment under this agreement unless compensation therefore is collected from said third person.

EXHIBIT F

GROUP INSURANCE RATES

Table 1

Hospital Confinement Benefits Rate per $1.00 of Daily Hospital Benefits

Percentage of Exposure on Eligible Females and Non-Caucasian Lives (Non-Caucasian Females Are Counted Twice)	*Special Services of 5 Times Daily Benefits*			*Special Services of 10 Times Daily Benefits*		
	31 Day Limit	*70 Day Limit*	*100 Day Limit*	*31 Day Limit*	*70 Day Limit*	*100 Day Limit*
Less than 11%	$.110	$.122	$.128	$.140	$.152	$.158
11% to less than 21%	.126	.140	.147	.161	.175	.182
21% to less than 31%	.137	.152	.160	.175	.190	.198
31% to less than 41%	.148	.165	.173	.189	.206	.214
41% to less than 51%	.159	.177	.186	.203	.221	.230
51% to less than 61%	.170	.189	.199	.217	.236	.246
61% to less than 71%	.181	.201	.211	.231	.251	.261
71% to less than 81%	.192	.213	.224	.245	.266	.277
81% to less than 91%	.203	.226	.237	.259	.282	.293
91% and over	.214	.238	.250	.273	.297	.309

Table 2

Surgical Benefits Rates per Employee Insured

	$75.00 Maximum	*$100.00 Maximum*	*$112.50 Maximum*	*$150.00 Maximum*	*$225.00 Maximum*
Less than 11%	$.20	$.27	$.30	$.40	$.70
11% to less than 21%	.23	.31	.35	.46	.81
21% to less than 31%	.25	.34	.38	.50	.88
31% to less than 41%	.27	.36	.41	.54	.95
41% to less than 51%	.29	.39	.44	.58	1.02
51% to less than 61%	.31	.42	.47	.62	1.09
61% to less than 71%	.33	.44	.50	.66	1.16
71% to less than 81%	.35	.47	.53	.70	1.23
81% to less than 91%	.37	.50	.56	.74	1.30
91% and over	.39	.52	.59	.78	1.37

Table 3

Medical Care Benefits (Doctor's Calls) Rates per Employee Insured

	1st 3 Calls Not Paid	*Hosp. Only 1st Call*	*1st Call Acc. 4th Call Sick*	*1st Call Hosp. 4th Call Home or Office*	*(e) 1st Call Hosp. 1st Call Acc. 4th Call Sick Outside Hosp.*
Less than 11%	$.35	$.15	$.40	$.40	$.45
11% to less than 21%	.40	.17	.45	.45	.52
21% to less than 31%	.44	.18	.50	.50	.56
31% to less than 41%	.47	.20	.54	.54	.61
41% to less than 51%	.51	.22	.58	.58	.65
51% to less than 61%	.54	.24	.62	.62	.70
61% to less than 71%	.58	.25	.66	.66	.74
71% to less than 81%	.61	.27	.70	.70	.79
81% to less than 91%	.65	.29	.74	.74	.83
91% and over	.68	.30	.78	.78	.88

Table 4

Diagnostic X-rays Outside Hospital

	Accident Only	*Accident or Sickness*	
	$25.00 Limit	*$15.00 Limit*	*$25.00 Limit*
Less 11%	$.05	$.10	$.15
11% to less than 21%	.05	.11	.17
21% to less than 31%	.05	.12	.18
31% to less than 41%	.05	.13	.19
41% to less than 51%	.05	.14	.20
51% to less than 61%	.05	.14	.21
61% to less than 71%	.05	.15	.22
71% to less than 81%	.05	.15	.23
81% to less than 91%	.05	.16	.24
91% and over	.05	.16	.25

Table 5

Extra Premiums for Industry

The percentage extras in the table below apply to Hospital Confinement Benefits and to Medical Care Benefits. No premium extras due to industry are charged for Surgical Benefits or for Diagnostic X-rays outside Hospital. The percentage extra in the Table below is to be added to the premium determined in Table 1 and 3 for the correct percentage of female and non-Caucasian employees. The list below included some of the more common industries requiring an extra premium. There are other industries involving an occupational health hazard sufficient to require an extra.

Industry	*Percentage Extra*
Breweries and Distilleries Industry	15%
Felt Hat Factories (refer to Home Office)	
If no carrotting	40%
Otherwise at least	70%
Farmers	15%
Hot Metal Industries	15%
Lime, Cement and Gypsum	15%
Marble and Stone Yards	15%
Miners and Quarries	40%
Refractories	15%
Textile	
Arkansas, Louisiana, Missouri, Oklahoma and Texas	40%
Elsewhere	15%
Wine Manufacturers and Wine Merchants	
Wholesale Liquor Dealers	15%
Woodsmen and Loggers—Saw Mills	25%

SECTION SEVEN

PROJECTS UNDER WAY

This report is filed six months before the sixty-seventh session of the Legislature and of necessity much of the additional research and investigation that might be performed is postponed or not undertaken because of the limitations of time. However, the Senate Interim Committee set up to study the same general subject has until the next session to make its report and it is to be expected that it will present additional data.

Also worthy of notice is the fact that at the first extraordinary session (1946) A.B. 88 was enacted whereby the State Department of Public Health is designated as the sole authorized agent of the State to make application for Federal funds and to accept such funds and provide for their expenditure under the provisions of the Federal Hospital Survey and Construction Act.

The act also provides for the making of survey of the hospital and health center facilities and needs of the State by the State Department of Public Health and development of a program for the construction of hospitals and health centers.

It is interesting to note that the opinion of this committee, expressed earlier in this report, that a shortage of hospitals and facilities exists is also the opinion of P. K. Gilman, M.D., Chief of the Bureau of Hospital Surveys who stated in a letter to the chairman dated June 10, 1946 as follows:

> "I am also taking the liberty of sending you a copy of some remarks of mine delivered to the Governor's Advisory Council on Hospital Facilities on the occasion of their organization meeting. This will serve to give you an idea of the purpose and planning of the survey and also serve to inform you of the inability, at the present time, of hospitalizing the population of California in need of such facilities."

It will be interesting to note how far the more detailed survey will substantiate that already made by this committee.

Dr. Gilman's remarks referred to above follow:

PURPOSE OF THE HOSPITAL SURVEY IN CALIFORNIA

P. K. Gilman, M.D., Chief, Bureau of Hospital Surveys
California State Department of Public Health

There exists a growing realization that the hospital is a responsibility of the community, not of the individual. The day is past when the philanthropic person or group may feel at liberty to independently erect facilities for the care of the sick on a site selected at random with consideration given but few of the myriad factors that should, after careful and widespread study, determine where such an institution would best be located. There is also an ever-increasing demand for adequate hospital facilities for all the people. The latter are fast coming to realize the hospital is a necessity in times of illness.

In the United States our standards of service are excellent and while it is true we have more hospital beds per population unit than in any other country, these beds are by no means equally distributed. Some areas are supplied in a fairly adequate manner, many areas have inadequate facilities, and in some areas these are completely lacking. This applies equally to California as well as to the country as a whole.

The modern staffed and well equipped hospital has many functions and in any comprehensive long-range health program should rightly be considered an indispensable distribution center for all types of medical service—preventive, diagnostic and therapeutic. Furthermore, in addition to providing care to restore those disables by injury or disease, it should function as a center not only for the maintenance and improvement of health, but for the continuing education of doctors, dentists, nurses and the related professions. Again further, the education of the general public on matters pertaining to health should not be neglected.

The American Hospital Association is organized for the purpose of raising the standards of hospital care for the people of this country. The Commission of Hospital Care is an independent entity and was organized prior to the introduction of legislation in Congress concerned with hospital construction. This Commission has planned the State surveys and inventories of hospital facilities and hopes to promote a study of such facilities in cooperation with those individuals and agencies interested in improving hospital and health service in each community.

The American Hospital Association, The Commission on Hospital Care and the American Medical Association have approved the granting of Federal funds to the States as one means of remedying the shortage and unequal distribution of hospital facilities. Such funds would assist in hospital construction in areas requiring such assistance either for the expansion of existing structures or the erection of new institutions.

The Hill-Burton Bill—S.B. 191—has been introduced in the Congress of the United States and proposes Federal assistance to the States. This bill has passed the Senate but has not as yet been acted upon by the lower house although no open opposition has to date developed. This bill proposes a program to be administered by State governmental authorities through the United States Public Health Service. It provides for Federal grants for; first, state-wide surveys of all existing hospital and public health facilities to be followed by coordinated state-wide plans programing facilities needed to supplement those already existing in order to serve all persons within the individual State. It further provides for the granting of Federal funds to construct or assist in constructing those needed public and other non-profit community hospital and public health facility projects in accord with the approved state-wide construction program.

A necessary preliminary to any request for Federal funds will be the State hospital survey and subsequent planning. A result of such will be a plan and construction program on a state-wide basis of need, supplementing rather than duplicating existing facilities. The Federal funds would be supplied to construct the physical plant and have no concern with Federal health insurance.

A further condition to be met in order to qualify for these grants-in-aid is assurance by the community to receive such funds of proper maintenance of the benefitting institutions. Such guarantee might well become difficult or impossible of fulfillment as a result of improper planning and programing of new construction.

Surveys have been completed or are nearing completion throughout the country under the central direction and assistance of the Commission Care inaugurated by the American Hospital Association.

In California A. B. 88 was passed by the legislature at its recent (1946) special sessions and signed by the Governor on February 25th, 1946. This act provides for the making of a survey of the hospital and health center facilities and needs of the State by the State Department of Public Health and development of a program for the construction of hospitals and health centers. It also creates a State Advisory Council on Hospital Facilities to consult with and advise the State Department of Public Health in carrying out the purposes of the act. Further the State Department of Public Health is solely authorized to make application on behalf of this state for Federal funds and to accept such funds and provide for their expenditure under the provision of the Federal Hospital Survey and Construction Act.

The institutions to be surveyed comprise those giving active in-bed care, excluding those providing custodial care as well as Federal hospitals, and rest homes where no medical care is provided.

With proper staff comprehending the objects and mechanics of the job it is planned to profit by the experience gained during the pioneer survey in Michigan and use will be made of the schedules developed by the Commission on Hospital Care.

The actual survey was preceded by proper publicity and the cooperation obtained of the Association of California Hospitals whose members are vitally interested since the survey itself was originally proposed by the American Hospital Association, has its full support and is probably the most important project ever undertaken by the hospitals of the State.

As a direct result of the cooperation on the part of the Hospital Association, the State has been divided into survey areas corresponding to the hospital districts set up by that organization. The area chairmen of these districts have been approached and their cooperation promised as liaison officers with whom field workers may arrange contacts and appointments for visits to the institutions within the district.

At the same time an active public relations and publicity campaign has been developed to educate not only the hospital personnel as to the objects of the survey, but the medical profession and the general public. These steps have facilitated the study since the actual work has been started.

The publicity was headed by a letter signed by the Governor urging full cooperation. This went to all the hospitals to be included in the survey approximately one week before the schedules of information were sent out. About two days following the letter from the Governor, one from the president of the Association of California Hospitals followed to the same institutions requesting prompt cooperation and accedance.

When the schedules of information were sent out two or three days later each was accompanied by a letter from the Bureau of Hospital Surveys indicating the manner in which they should be completed.

In the meantime additional publicity channels to be employed have been monthly bulletins of State and County Medical Societies, State Nursing Council, Blue Cross Plans, stories released to newspapers throughout the State to stimulate the interest of all groups, including the public, in hospitals.

Upon return of completed schedules of information, their subject matter will be classified and arranged and the accumulated data transferred to punch cards at the central office of the Commission on Hospital Care in Chicago. These cards will be made in duplicate and one set returned

to the office of the California Survey, the other retained in Chicago to form part of the nation-wide statistics concerning these facilities.

Utilizing the data thus secured, material will be at the disposal of the hospital Council and Bureau of Hospital Surveys from which estimates may be made as to the adequacy of hospital facilities in the various areas of California and recommendations evolved as to where and what types of institutions are required to make available such facilities to the people of the State.

The importance of this planning can not be too strongly stressed. It must be done in a broad-minded and objective manner uninfluenced by sectional competition. In other words, the State should be viewed as a whole in order to recommend proper distribution of facilities on a strictly factual basis rather than yielding to provincial pressure.

Before any recommendations may be intelligently arrived at many factors tabulated as a result of the survey must be carefully weighed. Each of these, the more obvious as well as those less so, will need study. Among these factors may be mentioned population density, relation to urban areas together with the size and distribution of these, availability of personnel to staff the institution, use of the hospital by the residents of a particular community, income level and standards of living and distances as interpreted in terms of topography, roads, means of transportation and climate.

All these operate to determine the extent of area to be served, the number of beds needed and the degrees of support which will be accorded the institutions which competed. Thus, the draft of a state-wide hospital plan may include recommendations for the extension of and addition to certain existing facilities as well as construction of new institutions in areas devoid of such conveniences.

The survey and its attendant publicity should accomplish more than a mere accumulation of data relating to the extent of available facilities existing at the present time. Many hospitals have failed in the past and at present many more, in the struggle for existence, of necessity, render sub-standard service. These failures will not tend to decrease as exaggerated war-time conditions of population and income return to a more normal level. Since hospitals depend upon the public for their support they should be erected in response to community need. Each community must be studied on the spot if costly errors are to be avoided. In other words, it is impossible to arbitrarily lay down hard and fast rules regarding the size of a hospital community and the bed capacity and location of the hospital without taking into account many factors.

Consideration of the population served demands determination of several factors. Population trends over a sufficiently extended period will give valuable information, especially if considered in conjunction with the sickness rate and hospital habits of the area and population density as well as accessibility of tributary areas. It is conceded that with population of less than 6 per mile a hospital is not practicable but with more than this figure a hospital is practicable and necessary.

With good roads and adequate means of transportation only exceptional cases may not be safely moved up to forty miles in a level district. In mountainous areas with less direct and steeper roads and more severe weather conditions facilities should be more accessible.

Careful consideration must be given the character of the hospital as to professional standards and accessibility to people unable to pay as well as those able. Actual beds are but one need in the community. The quality of the service rendered, the availability of physicians to staff the hospital and their attitudes and customs in reference to hospitals will have influence upon the support accorded the community project or whether this support will be given similar facilities in adjacent communities.

To attract doctors to rural areas there must be provided, in addition to modern hospital facilities, an assurance of an adequate income as well as opportunities for study and research. To accomplish these conditions careful planning and cooperation on a community level are necessary. At present in the majority of rural communities the average physician spends a large part of his time in travel from patient to patient. The assembling of adequate facilities combined with office space for private physicians as well as members of the health department and allied services will increase the efficiency of those rendering the service and improve the quality of those services.

The program suggested is one which will require considerable time to carry out to its ultimate goal. It will set up for the first time a *system* of hospitals in contradistinction to a series of independent and often competing institutions. If proper planning be initiated and perpetrated, if coordinated effort from wholehearted community and State cooperation rather than competition become the pattern, not only will proper hospital facilities for the people of California result, but the standards of preventive medicine, diagnostic procedures and therapeutics will be raised and their benefits made available to all.

Since it is evident that establishing a State system of prepaid medical care must perforce wait the expansion of facilities it is nevertheless not the intention of either the medical fraternity or the commercial insurance firms to cease expanding their coverage under voluntary plans.

It is the opinion of this committee that the report to be brought in by the State Department of Public Health as outlined on the preceding pages by Dr. Gilman will contain much factual information necessary to the Legislature before it can proceed with any plans which might throw additional burdens on the hospitals of California at this time.

SECTION EIGHT

PUBLIC OPINION

Since what is to be known concerning the cost and operation of prepaid health plans can only be brought to light by the expenditure of considerable time and effort, this committee has not felt that the general public is in a position to give an unqualified answer to the question:—"Do you favor a State Plan of Prepaid Medical Care?"

However, the members of this committee determined that a survey which would bring to light other matters having a bearing on the subjects pertain to our study might be of value.

Therefore, the firm, "California Associates," was employed to make a survey and tabulate the results. The survey as delivered to the committee is incorporated as the balance of this section and the foreword explains how it was conducted and the question sheet furnished the interviewers is reproduced.

The only question which may be regarded as "slanted" is that where the word "compulsory" is used—yet to avoid the word would have been to "slant" the question in a different way or to fail to bring to light the distinction between "compulsory" and "voluntary" plans.

For visual reference as to the areas covered by the survey we have interpolated in the report an outline map of California in which the outlines of the areas are delineated.

Since the copies of the survey report were prepared at a different time than that in which this report was typed the pages are not numbered but the tables are identified numerically for reference.

Significant results of the tabulations appearing in the survey report are noted below.

Coverage

327 per 1,000 families interviewed carried insurance against medical cost.

Incidence of Use

430 per 1,000 persons insured received care under the plan.

Satisfaction

925 per 1,000 persons receiving care were satisfied.

Extra Charges

487 per 1,000 persons receiving service paid additional charges 81.3% of these thought the extra charge was fair.

Compulsion

76% believed membership should be voluntary.

State Competition

50.2% of persons interviewed believed the State should promote and operate a competitive plan.

Choice of Plan

56.9% of those believing membership should be compulsory preferred free choice as between State or private plan.

Financing of Plan

348 per 1,000 favored payroll tax.
209 per 1,000 favored sales tax.
67 per 1,000 favored property tax.
244 per 1,000 favored some other method of paying for service.

Types of Healers

265 per 1,000 preferred M.D.'s only.
735 per 1,000 would include other professions as follows:
10.9% would include Osteopaths
17.1% would include Chiropractors
1.1% would include Drugless healers

The variations in the answers as determined by area, occupation, union membership, etc. are interesting and covered in detail in the following reproduction of the complete report.

STATE-WIDE PUBLIC OPINION SURVEY

MADE EXPRESSLY FOR

ASSEMBLY INTERIM COMMITTEE ON HEALTH CARE
(As authorized by H.R. 295)

By

KNIGHT AND PARKER
CALIFORNIA ASSOCIATES

March, 1946

FOREWORD

Pursuant to a letter of instructions, dated December 8, 1945, signed by Hon. Ernest R. Geddes, Chairman of the Assembly Health Care Investigating Interim Committee, we submit the findings of a Public Opinion Survey, attached hereto and made a part hereof.

These findings are the result of the personal interrogation of 3,460 adult persons in the State of California, properly distributed according to the attached tabulation entitled "Area Distribution."

Each person interrogated, hereinafter referred to as respondent, was interviewed by means of an individual printed questionnaire. The interviewer carefully read verbatim each question contained in said questionnaire without any explanation or other conversation, which would or could in any manner, shape or form, influence the response.

A copy of the instructions sent to and complied with by each interviewer is attached hereto. In order to insure a representative cross-section within each area, the interviewers were properly proportioned and controlled by sex, age, property ownership, union affiliation, occupation, and location of residence, such as urban and rural. Moreover, all persons interviewed were first qualified to be either a wage earner, wife of a wage earner, or husband of a wage earner, thus assuring the committee that only these persons with specific knowledge of the family status were interviewed for the purpose of obtaining opinions to form a part of this report.

In order to insure the adequacy of the cross-section, a correlation chart was maintained on several key questions, the result of which determined that the number of interviews obtained were and are a representative cross-section with a maximum possible error factor of 2% on the overall.

The questionnaire approved by the Chairman of this Committee was actually prepared by said committee, without the assistance of Knight and Parker, except that at the request and instance of the committee, a pilot run was made by Knight and Parker consisting of approximately 100 interviews and the report thereon made to the Chairman of the Committee. As a result of the said pilot run, it was determined that the questions prepared by the committee evoked answers responsive to the question; that the questions were clear and fully understood; that they were not ambiguous and did not require any explanation on the part of the interviewer in order to permit the respondent to give his reply; and that the answers would develop information of the type required by the committee for its consideration of the problem. At this point, it must be clearly understood that the committee did not desire a questionnaire which would develop information to prove a pre-conceived point. The type of information to be gathered was such as would accomplish the objectives of the committee.

These objectives are as follows:

1. To determine what percentage of the population is not now covered by some type of medical care plan and, thereby, determine the percentage of need for a State program.

2. To determine whether or not the service, care or treatment rendered under existing plans is satisfactory.

3. To find out what percentage of the public favored compulsory subscription to or membership in a medical or hospital plan.

4. To determine what percentage of the public favored the idea of the State of California promoting and operating a plan of its own in competition with existing programs or services.

5. To obtain from the people an expression as to the source of revenue for which to pay for such a State plan.

6. To determine which types of practitioners should be permitted to practice under such a plan.

All of these objectives have been accomplished as evidenced by the findings of this report and the report is hereby respectfully submitted.

KNIGHT AND PARKER
By John B. Knight
Geraldine Parker

INSTRUCTIONS TO INTERVIEWERS

We are very glad that you will be able to assist us in our state-wide survey. Sorry about the delay in getting the materal to you, but we were unavoidably delayed. The following instruction will help you in your interviewing:

1. You are being sent a CONTROL SHEET. The number in red in the upper right hand corner of this sheet denotes the total number of interviews you are to make. These must be scattered about in your area and must include urban, rural, and each of the occupation, age, sex and political groups as indicated on your control sheet. The numbers circled in red will indicate how many interviews you make in each group. For instance, you may be required to interview 40 men and 60 women. In this case, the numbers 40 and 60 will be circled after men and women, respectively. THESE CONTROLS MUST BE STRICTLY ADHERED TO. PLEASE KEEP A RUNNING CHECK BY MARKING OFF IN PENCIL THE CLASSIFICATIONS OF EACH INTERVIEW AS IT IS MADE. Send in your control sheet with the completed interviews.

As a guide to the occupation classifications, you will use the following:

1. The Proprietor-Manager-Official group will include all those people who act in an ownership or managerial capacity.

2. The Professional group will include all the usual professions plus anyone who has had extensive study in a given field, i.e. music or other arts.

3. Clerical Sales or Office worker group is self-explanatory.

4. Laborers and Wage Earners group will include anyone who works with his hands in a shop, driving a bus, etc.

5. Domestic Service group will include all maids, chauffeurs, waitresses, bartenders, cooks, etc.

2. The numbers that you find on the questionnaire are what we call code numbers and should be circled IN RED PENCIL to indicate the answers given by the person interviewed. See the sample form we have attached to this letter.

3. Before beginning the interview, be sure that the person you are talking to will fit into one of the three groups named at the top of the page: Wage Earner, Wife of Wage Earner, Husband of Wage Earner. If he or she is not in one of these groups, do not interview them.

Be sure to answer every question. Read the instructions written in Capital letters preceding certain questions. For instance, note that those who answer that none of their family belongs to a medical insurance group should not be asked questions 2 through 5. All words in capitals are instructions and should not be read to the respondent.

4. DK stands for Don't Know on all the Questions.

5. In question 8 the interviewer must refer back to question 6. If the answer in question 6 was *Compulsory*, ask question 8, if not, skip the question entirely.

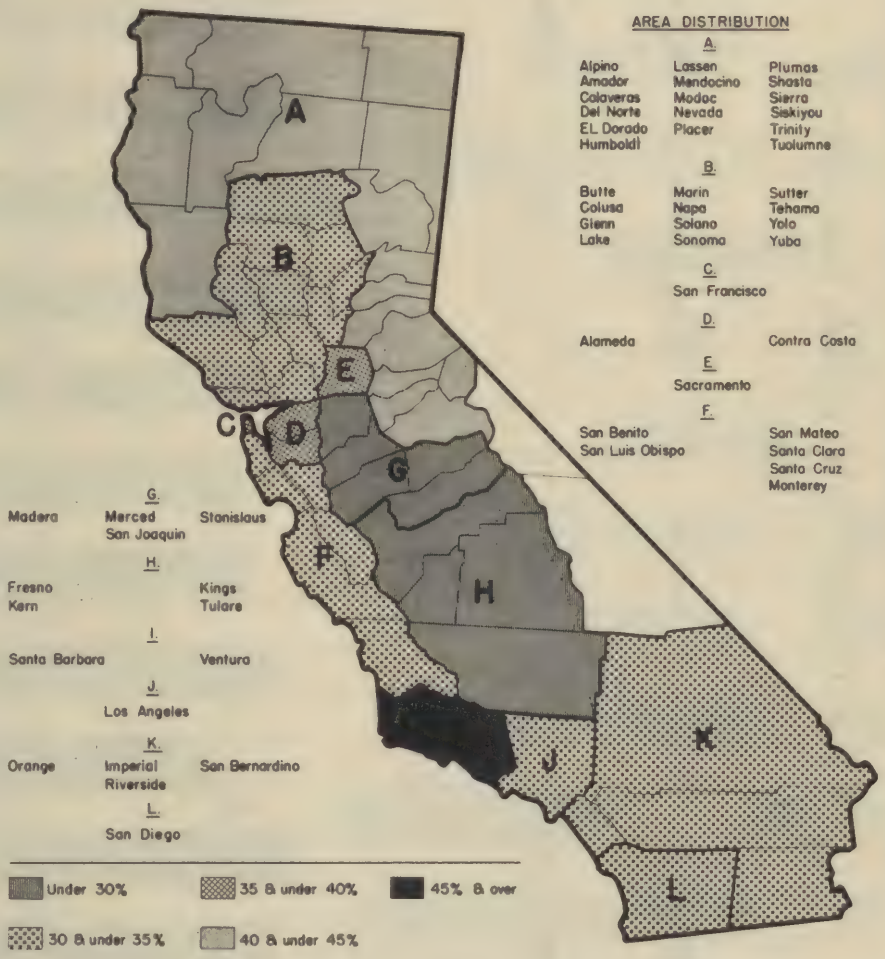
6. Questions 9 and 10. Circle choice of respondent. If the respondent makes more than one selection, be sure to circle each answer he feels to be important.

7. In question 10, the term "other" will denote anyone in any other classification than those listed. The drugless healers will mean those not using drugs.

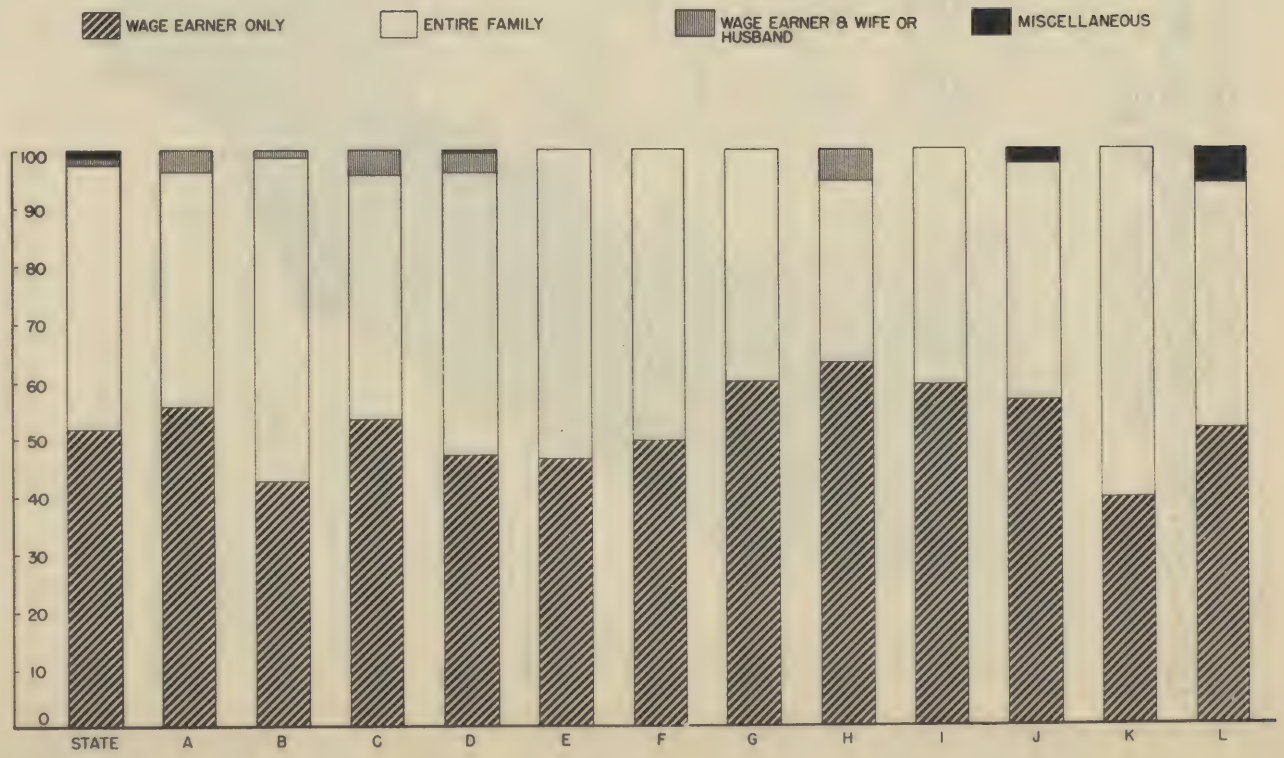
Controls—Be sure to answer and check all controls—number in family, sex, age, property owner, union, occupation, location. We can not pay for incomplete interviews.

We would like to have all of your interviews in our office not later than March 1. Please let us know if you have any questions. Thank you again for your help.

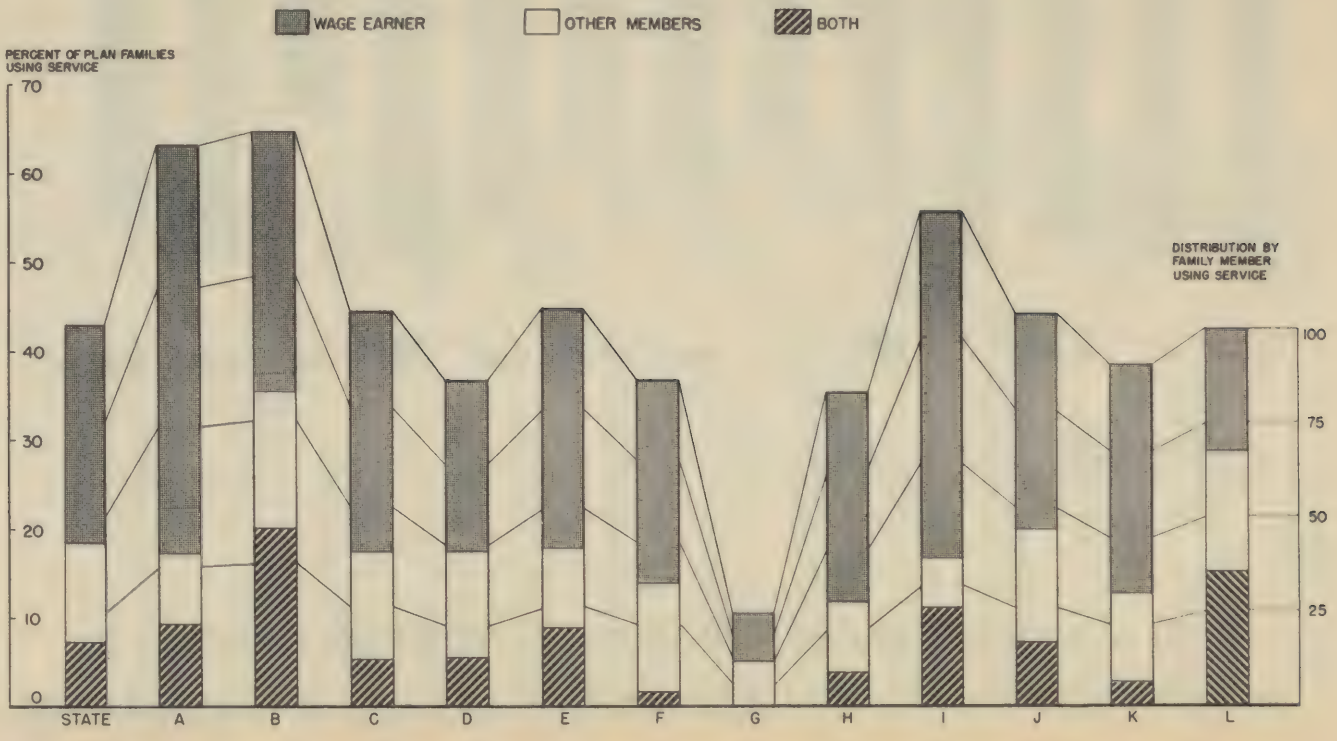
EXTENT OF PARTICIPATION IN GROUP MEDICAL OR HOSPITAL CARE PLANS IN CALIFORNIA BY AREA, March 1946.



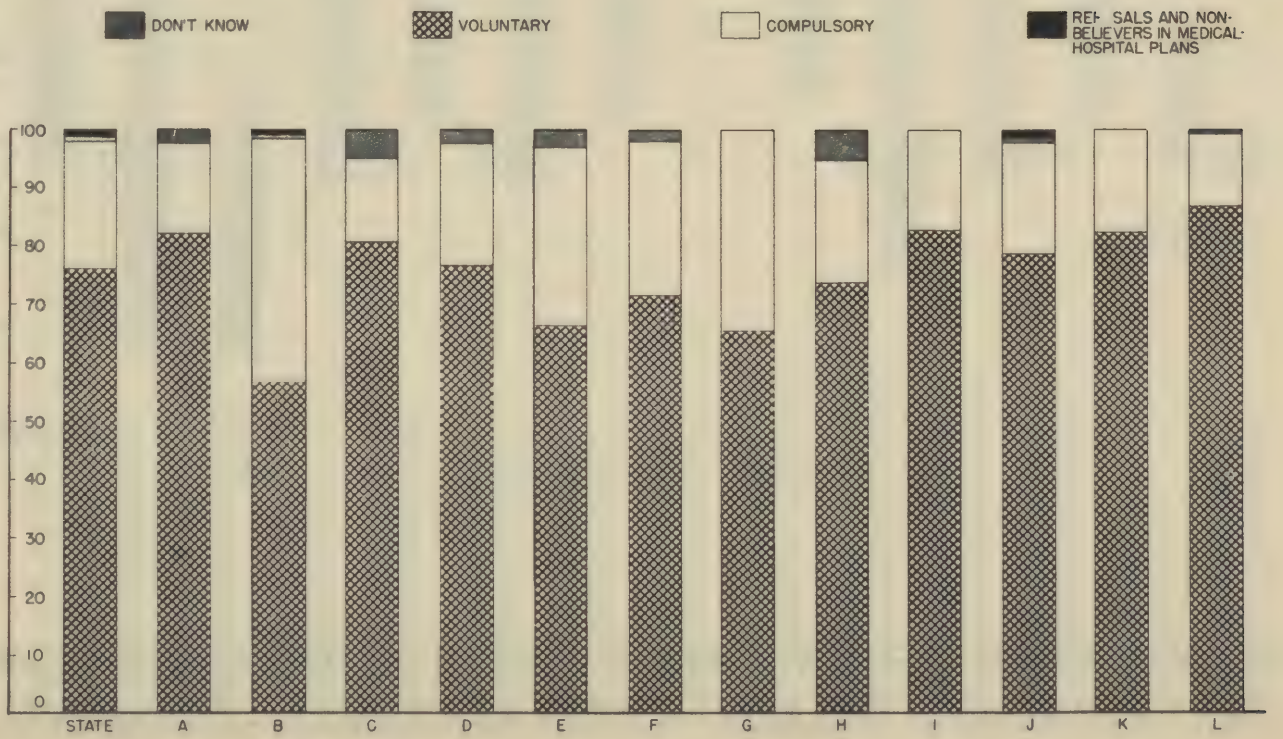
NATURE OF COVERAGE OF HOSPITAL-MEDICAL PLAN PARTICIPANTS BY AREA, March 1946



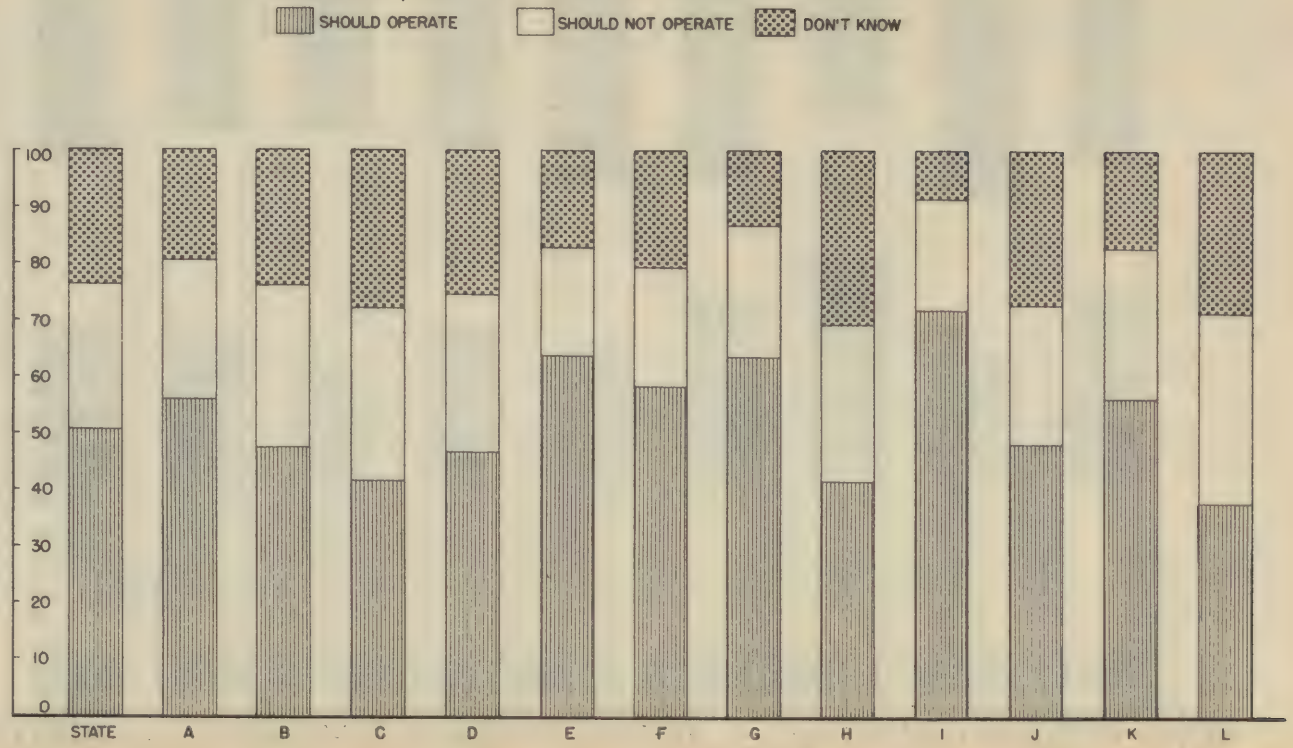
PERCENTAGE DISTRIBUTION OF MEDICAL-HOSPITAL PLAN FAMILIES WHO HAVE RECEIVED SERVICE, BY AREA & FAMILY MEMBER, California, March 1946



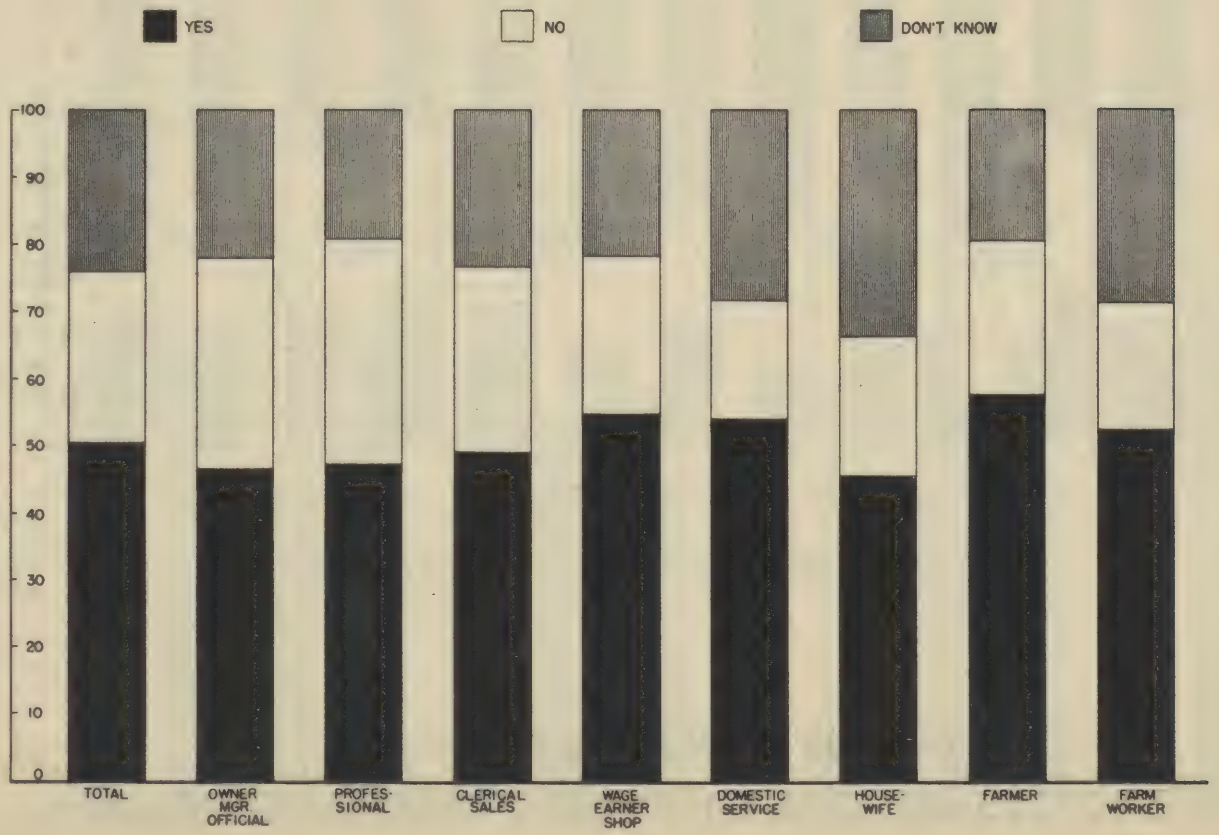
DISTRIBUTION OF OPINION ON VOLUNTARY OR COMPULSORY NATURE OF HOSPITAL-MEDICAL GROUP PLANS BY AREA, March 1946



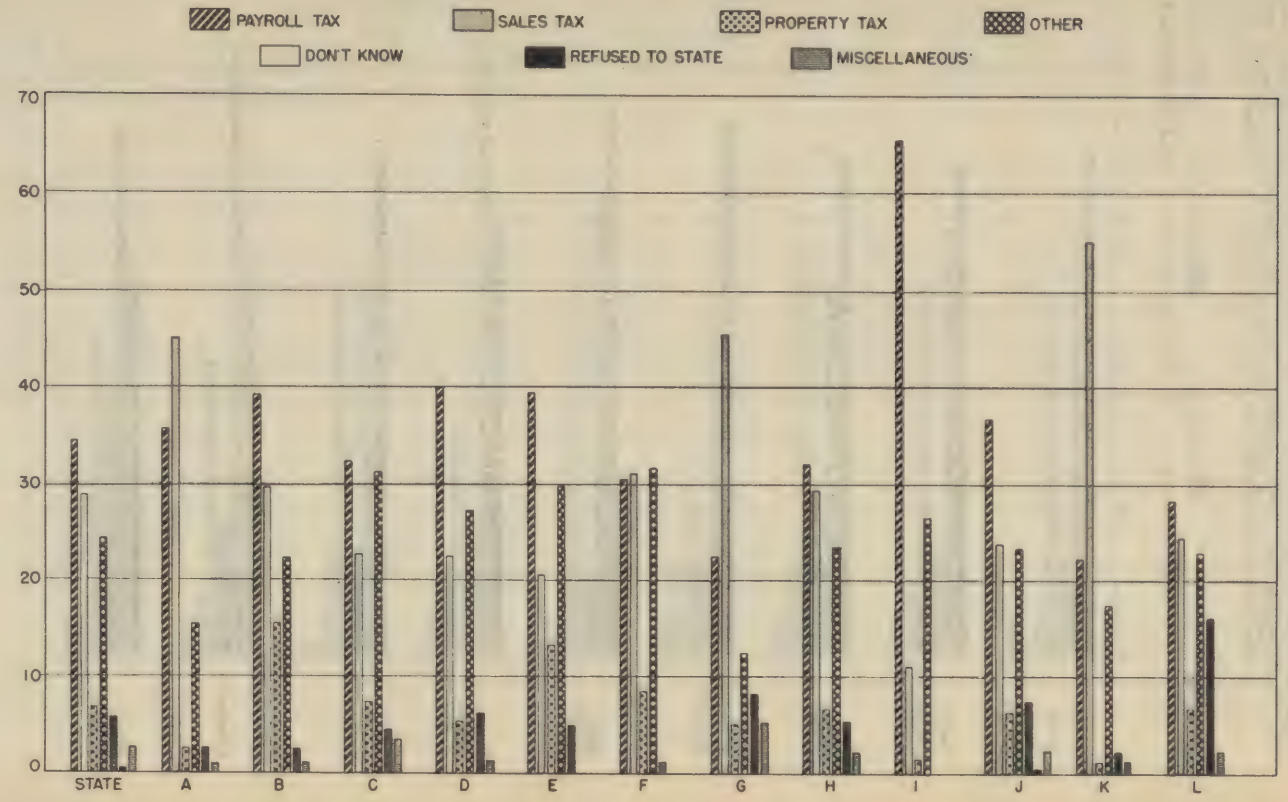
EXTENT OF FAVORABLE OPINION ON STATE OPERATED MEDICAL HOSPITAL PLAN BY AREA, March 1946



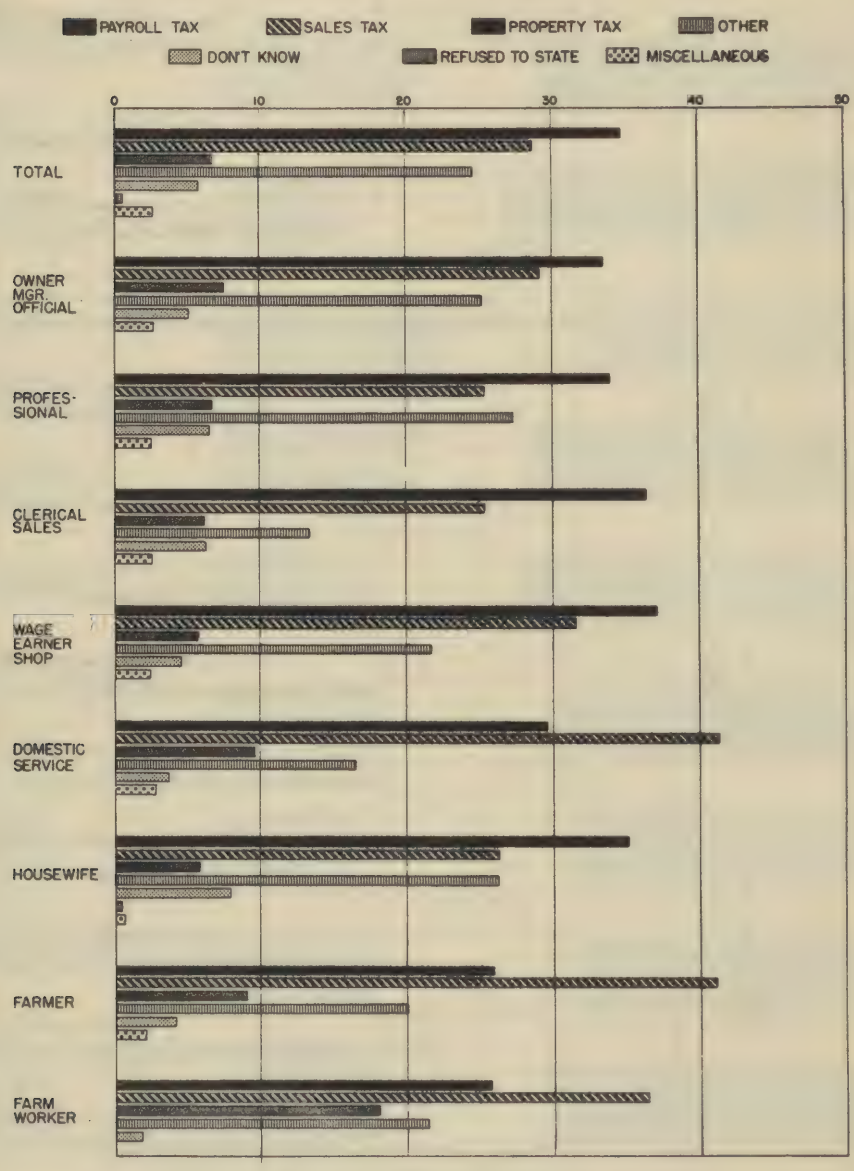
EXTENT OF FAVORABLE OPINION ON STATE OPERATED MEDICAL-HOSPITAL PLAN BY OCCUPATION OF RESPONDENT, March 1946.



PREFERRED METHODS OF FINANCING STATE MEDICAL-HOSPITAL PLANS BY AREA, March 1946



PREFERRED METHODS OF FINANCING STATE MEDICAL-HOSPITAL PLANS, BY OCCUPATION OF RESPONDENT, March 1946.



DISTRIBUTION OF SAMPLE

All persons interviewed must *first* be qualified to be in one of the following classifications.

	Total	*Area A*	*Area B*	*Area C*	*Area D*	*Area E*	*Area F*	*Area G*	*Area H*	*Area I*	*Area J*	*Area K*	*Area L*
Interviews	100.0%	100.0	100.0	100.0	100.1	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Wage earner	68.2%	74.6	63.1	70.1	58.2	72.6	73.2	69.3	72.3	80.5	68.8	68.8	65.3
Wife of wage earner	30.8	24.6	35.7	29.9	40.9	27.4	24.7	30.7	27.7	19.5	29.7	29.4	34.7
Husband of wage earner	.5	.8	.8	---	.9	---	.4	---	---	---	.5	1.1	---
Wage earner and wife of wage earner	.5	---	.4	---	---	---	1.7	---	---	---	1.0	.7	---

SUBSCRIBERS TO MEDICAL PLAN

1. Who, living in this household, subscribes, belongs to, or is taken care of under any medical or hospital group or insurance plan?

	Total	*Area A*	*Area B*	*Area C*	*Area D*	*Area E*	*Area F*	*Area G*	*Area H*	*Area I*	*Area J*	*Area K*	*Area L*
None	67.3%	57.0	68.5	64.4	61.8	63.7	66.9	78.5	77.7	54.9	69.7	65.6	65.3
Those having plan	32.7	43.0	31.5	35.6	38.2	36.3	33.1	21.5	22.3	45.1	30.3	34.4	34.7
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Wage earner only	51.7%	55.8	42.1	53.5	47.0	46.7	49.5	60.0	63.0	59.5	56.7	39.6	51.5
Entire family	45.8	40.4	56.6	42.4	49.4	53.3	50.5	40.0	31.5	40.5	40.7	60.4	42.4
Wage earner and wife or husband	1.3	3.8	1.3	4.1	3.0	---	---	---	5.5	---	---	---	---
Miscellaneous	1.2	---	---	---	.6	---	---	---	---	---	2.6	---	6.1

MEMBERS RECEIVING CARE

2. Which member or members of this family have received medical or hospital care under the plan?

	Total	*Area A*	*Area B*	*Area C*	*Area D*	*Area E*	*Area F*	*Area G*	*Area H*	*Area I*	*Area J*	*Area K*	*Area L*
Those having plan	(32.7%)	(43.0)	(31.5)	(35.6)	(38.2)	(36.3)	(33.1)	(21.5)	(22.3)	(45.1)	(30.3)	(34.4)	(34.7)
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
None	57.0	36.5	35.5	56.6	63.1	55.6	63.1	88.6	64.8	44.4	55.7	61.5	57.6
Received care	43.0	63.5	64.5	43.4	36.9	44.4	36.9	11.4	35.2	55.6	44.3	38.5	42.4
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Wage earner	56.7%	72.7	44.8	60.5	53.2	60.0	60.0	50.0	68.4	70.0	54.9	67.6	32.1
Other members of family	26.3	12.1	22.5	27.9	32.3	20.0	34.3	50.0	21.1	10.0	28.6	24.3	32.1
Both	17.0	15.2	32.7	11.6	14.5	20.0	5.7	---	10.5	20.0	16.5	8.1	35.8

SATISFACTORY SERVICE

3. (IF TREATMENT OR CARE RECEIVED, ASK) Was the service, care or treatment entirely satisfactory?

	Total	*Area A*	*Area B*	*Area C*	*Area D*	*Area E*	*Area F*	*Area G*	*Area H*	*Area I*	*Area J*	*Area K*	*Area L*
Those who have received care	(43.0%)	(63.5)	(64.5)	(43.4)	(36.9)	(44.4)	(36.9)	(11.4)	(35.2)	(55.6)	(44.3)	(38.5)	(42.4)
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Yes	92.5%	97.0	85.7	100.0	95.2	100.0	82.3	100.0	100.0	95.0	91.7	88.9	89.3
No	6.5	---	12.2	---	3.2	---	17.7	---	---	---	7.6	11.1	10.7
Don't know	1.0	3.0	2.1	---	1.6	---	---	---	---	5.0	.7	---	---

ADDITIONAL PAYMENTS MADE

4. Did you have to pay the doctor or hospital anything extra?

	Total	*Area A*	*Area B*	*Area C*	*Area D*	*Area E*	*Area F*	*Area G*	*Area H*	*Area I*	*Area J*	*Area K*	*Area L*
Those who have received care	(43.0%)	(63.4)	(64.5)	(43.4)	(36.9)	(44.4)	(36.9)	(11.4)	(35.2)	(55.6)	(44.3)	(38.5)	(42.4)
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Yes	48.7%	42.4	49.0	39.5	54.8	70.0	54.3	50.0	57.9	50.0	48.5	41.7	35.8
No	48.2	54.5	32.7	58.2	45.2	30.0	40.0	50.0	42.1	50.0	51.5	58.3	57.1
Don't know	3.1	3.1	18.3	2.3	---	---	5.7	---	---	---	---	---	7.1

FAIRNESS OF ADDITIONAL CHARGE

5. (IF HAD TO PAY EXTRA) Was the extra charge fair?

	Total	*Area A*	*Area B*	*Area C*	*Area D*	*Area E*	*Area F*	*Area G*	*Area H*	*Area I*	*Area J*	*Area K*	*Area L*
Those paying extra charge	(48.7%)	(42.4)	(49.0)	(39.5)	(54.8)	(70.0)	(54.3)	(50.0)	(57.9)	(50.0)	(48.5)	(41.7)	(35.8)
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Yes	81.3%	85.7	75.0	100.0	94.1	84.6	52.6	100.0	81.8	90.0	79.0	66.7	90.0
No	13.9	7.2	20.8	---	5.9	7.7	42.1	---	9.1	10.0	12.9	26.7	10.0
Don't know	4.8	7.1	4.2	---	---	7.7	5.3	---	9.1	---	8.1	6.6	---

ATTITUDE TOWARD COMPULSORY MEMBERSHIP

6. Do you think that subscription to or membership in a medical or hospital plan should be compulsory or voluntary?

	Total	*Area A*	*Area B*	*Area C*	*Area D*	*Area E*	*Area F*	*Area G*	*Area H*	*Area I*	*Area J*	*Area K*	*Area L*
Interviews	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Voluntary	76.0%	81.8	56.5	80.9	76.4	66.7	71.1	65.6	73.1	82.9	78.9	82.4	86.3
Compulsory	21.7	15.7	41.9	14.4	20.9	30.1	26.8	34.4	21.1	17.1	19.2	17.6	12.1
Don't know	2.1	2.5	.8	4.7	2.7	3.2	2.1	---	5.8	---	1.7	---	1.6
Do not believe in it	.1	---	---	---	---	---	---	---	---	---	.1	---	---
Refused to state	.1	---	.8	---	---	---	---	---	---	---	.1	---	---

OPINION ON STATE-OPERATED PLAN

7. There are now available several different types of medical and hospital plans. Do you think the State of California should promote and operate a plan in competition to those in existence?

	Total	*Area A*	*Area B*	*Area C*	*Area D*	*Area E*	*Area F*	*Area G*	*Area H*	*Area I*	*Area J*	*Area K*	*Area L*
Interviews	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Yes	50.2%	56.2	47.5	41.7	46.8	63.9	58.4	63.6	42.0	71.6	48.5	56.3	37.8
No	25.8	24.8	28.8	30.6	27.9	18.9	21.1	23.5	27.3	19.8	24.0	26.7	33.5
Don't know	24.0	19.0	23.7	27.7	25.3	17.2	20.5	12.9	30.7	8.6	27.5	17.0	28.7

ATTITUDE TOWARD COMPULSORY MEMBERSHIP IN STATE PLAN

8. (IF COMPULSORY ANSWERED TO QUESTION No. 6) Should people be compelled to belong to or subscribe to the State Plan or should they be allowed to take their choice?

	Total	*Area A*	*Area B*	*Area C*	*Area D*	*Area E*	*Area F*	*Area G*	*Area H*	*Area I*	*Area J*	*Area K*	*Area L*
Those who believe in compulsory membership	(21.7%)	(15.7)	(41.9)	(14.4)	(20.9)	(30.1)	(26.8)	(34.4)	(21.1)	(17.1)	(19.2)	(17.6)	(12.1)
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Allowed to take choice	56.9%	57.9	37.4	75.7	68.1	62.2	51.4	36.4	68.1	46.2	63.6	51.1	66.7
Should be compelled to belong	42.9	42.1	61.6	24.3	31.9	37.8	48.6	63.6	31.9	53.8	35.9	48.9	33.3
Don't know	.1	---	---	---	---	---	---	---	---	---	.5	---	---
Refused to state	.1	---	1.0	---	---	---	---	---	---	---	---	---	---

FINANCIAL SOURCES FOR STATE PLAN

9. If the State should start such a plan, how should it be paid for?

	Total	Area A	Area B	Area C	Area D	Area E	Area F	Area G	Area H	Area I	Area J	Area K	Area L
Interviews	*100.0%	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0	100.0	100.0	*100.0	*100.0	*100.0	*100.0
Payroll tax	34.8%	35.8	39.2	32.3	40.0	39.7	30.7	22.9	32.4	65.8	37.1	22.3	28.6
Sales tax	28.9	45.0	29.7	22.5	22.7	20.7	31.1	45.9	29.4	11.4	24.0	55.7	24.9
Property tax	6.7	2.5	15.5	7.3	5.5	13.2	8.5	5.1	6.7	1.3	6.4	1.1	6.9
Other	24.4	15.8	22.4	31.3	27.7	29.8	31.8	12.7	23.9	26.6	23.6	17.9	23.3
Don't know	5.6	2.5	2.2	4.4	6.2	5.0	---	8.3	5.5	---	7.6	2.2	16.4
Refused to state	.1	---	---	---	---	---	---	---	---	---	.1	---	---
Miscellaneous	2.5	.8	.9	3.3	1.5	---	1.2	5.1	2.1	---	2.3	1.2	1.6

* Totals to more than 100% because of multiple answers.

ELIGIBILITY OF VARIOUS TYPES OF HEALERS

10. If a State plan should be adopted, should it include treatment by Osteopaths, Chiropractors, Other, Drugless healers, All, None?

	Total	Area A	Area B	Area C	Area D	Area E	Area F	Area G	Area H	Area I	Area J	Area K	Area L
None	26.5%	10.7	34.9	41.2	34.8	17.9	34.8	26.5	16.2	22.2	24.0	12.8	27.1
Those who would include	73.5	89.3	65.1	58.8	65.2	82.1	65.2	73.5	83.8	77.8	76.0	87.2	72.9
	*100.0%	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0
All	70.7%	83.3	72.2	76.7	74.2	58.4	59.9	53.8	77.7	66.7	66.5	87.9	68.7
Osteopaths	19.9	11.1	9.3	19.6	16.4	33.7	36.4	39.5	12.4	28.6	22.8	3.3	16.8
Chiropractors	17.1	12.0	17.9	16.0	13.2	29.7	24.6	38.7	9.9	25.4	18.1	8.4	7.3
Drugless healers	1.1	---	1.3	1.2	2.1	5.0	---	.8	---	1.6	1.3	---	---
Dentists	.4	---	---	---	---	---	---	.8	---	---	1.2	---	---
Other	6.5	5.6	2.6	---	2.4	16.8	1.1	2.5	6.9	1.6	12.2	1.7	8.0
Against it	.1	---	.7	---	---	---	---	---	---	---	---	---	---
Don't know	2.5	---	4.0	2.5	3.8	2.0	---	1.7	2.5	1.6	2.2	.8	8.8

* Totals to more than 100% because of multiple answers.

SEX—DISTRIBUTION OF SAMPLE

All persons interviewed must *first* be qualified to be in one of the following classifications.

	Total	*(49.1) Male*	*(50.9) Female*
Interviews	100.0%	100.0	100.0
Wage Earner	68.2%	97.4	40.0
Wife of wage earner	30.8	----	59.2
Husband of wage earner	.5	2.3	----
Wage earner and wife of wage earner	.5	.3	.8

SEX—SUBSCRIBERS TO MEDICAL PLAN

1. Who, living in this household, subscribes, belongs to, or is taken care of under any medical or hospital group or insurance plan?

	Total	*Male*	*Female*
None	67.3%	67.4	67.3
Those having plan	32.7	32.6	32.7
	100.0%	100.0	100.0
Wage Earner only	51.7	50.7	52.3
Entire Family	45.8	46.6	45.5
Wage earner and wife or husband	1.3	1.3	1.0
Miscellaneous	1.2	1.4	1.2

SEX—MEMBERS RECEIVING CARE

2. Which member or members of this family have received medical or hospital care under the plan?

	Total	*Male*	*Female*
Those having plan	(32.7%)	(32.6%)	(32.7%)
	100.0%	100.0	100.0
None	57.0	54.8	58.9
Received care	43.0	45.2	41.1
	100.0%	100.0	100.0
Wage Earner	56.7%	55.7	57.4
Other members of family	26.3	28.0	24.7
Both	17.0	16.3	17.9

SEX—SATISFACTORY SERVICE

3. (IF TREATMENT OR CARE RECEIVED, ASK) Was the service, care or treatment entirely satisfactory?

	Total	*Male*	*Female*
Those who have received care	(43.0%)	(45.2)	(41.1)
	100.0%	100.0	100.0
Yes	92.5%	91.1	94.4
No	6.5	7.7	4.7
Don't know	1.0	1.2	.9

SEX—ADDITIONAL PAYMENTS MADE

4. Did you have to pay the doctor or hospital anything extra?

	Total	*Male*	*Female*
Those who have received care	(43.0%)	(45.2)	(41.1)
	100.0%	100.0	100.0
Yes	48.7%	49.4	47.4
No	48.2	48.6	48.3
Don't know	3.1	2.0	4.3

SEX—FAIRNESS OF ADDITIONAL CHARGE

5. (IF HAD TO PAY EXTRA) Was the extra charge fair?

	Total	*Male*	*Female*
Those paying extra charge	(48.7%)	(49.4)	(47.4)
	100.0%	100.0	100.0
Yes	81.3%	77.3	86.2
No	13.9	16.0	11.0
Don't know	4.8	6.7	2.8

SEX—ATTITUDE TOWARD COMPULSORY MEMBERSHIP

6. Do you think that subscription to or membership in a medical or hospital plan should be compulsory or voluntary?

	Total	*Male*	*Female*
Interviews	100.0%	100.0	100.0
Voluntary	76.0%	73.9	78.0
Compulsory	21.7	23.7	19.9
Don't know	2.1	2.2	2.0
Do not believe in it	.1	----	.1
Refused to state	.1	.2	----

SEX—OPINION ON STATE-OPERATED PLAN

7. There are now available several different types of medical and hospital plans. Do you think the State of California should promote and operate a plan in competition to those in existence?

	Total	*Male*	*Female*
Interviews	100.0%	100.0	100.0
Yes	50.2%	53.1	47.3
No	25.8	29.0	22.8
Don't know	24.0	17.9	29.9

SEX—ATTITUDE TOWARD COMPULSORY MEMBERSHIP IN STATE PLAN

8. (IF COMPULSORY ANSWERED TO QUESTION No. 6) Should people be compelled to belong to or subscribe to the State Plan or should they be allowed to take their choice?

	Total	*Male*	*Female*
Those who believe in compulsory membership	(21.7%)	(23.7)	(19.9)
	100.0%	100.0	100.0
Allowed to take choice	56.9%	53.4	60.8
Should be compelled to belong	42.9	46.4	38.9
Don't know	.1	.2	----
Refused to state	.1	----	.3

SEX—FINANCIAL SOURCES FOR STATE PLAN

9. If the State should start such a plan, how should it be paid for?

	Total	*Male*	*Female*
Interviews	*100.0%	*100.0	*100.0
Payroll tax	34.8%	34.3	35.3
Sales Tax	28.9	31.1	26.9
Property tax	6.7	7.5	5.9
Other	24.4	22.9	25.9
Don't know	5.6	4.3	6.9
Refused to State	.1	----	.1
Miscellaneous	2.5	2.4	1.4

* Totals to more than 100% because of multiple answers.

SEX—ELIGIBILITY OF VARIOUS TYPES OF HEALERS

10. If a State plan should be adopted, should it include treatment by Osteopaths, Chiropractors, Other, Drugless healers, All, None?

	Total	*Male*	*Female*
None	26.5%	26.0	27.0
Those who would include	73.5%	74.0	73.0
	*100.0%	*100.0	*100.0
All	70.7%	71.5	70.1
Osteopaths	19.9	20.6	19.3
Chiropractors	17.1	18.1	16.3
Drugless healers	1.1	1.1	1.0
Dentists	.4	.2	.5
Other	6.5	6.0	6.9
Against it	.1	.1	----
Don't know	2.5	1.9	3.0

* Totals to more than 100% because of multiple answers.

AGE—DISTRIBUTION OF SAMPLE

All persons interviewed must *first* be qualified to be in one of the following classifications.

	Total	*20-29* (21.3)	*30-39* (24.1)	*40-49* (21.8)	*50-Up* (32.8)
Interviews	100.0%	100.0	100.0	100.0	100.0
Wage earner	68.2%	69.5	65.4	67.2	70.3
Wife of wage earner	30.8	29.2	33.8	32.4	28.6
Husband of wage earner	.5	.5	.2	.3	.7
Wage earner and wife of wage earner	.5	.8	.6	.1	.4

AGE—SUBSCRIBERS TO MEDICAL PLAN

1. Who, living in this household, subscribes, belongs to, or is taken care of under any medical or hospital group or insurance plan?

	Total	*20-29*	*30-39*	*40-49*	*50-Up*
None	67.3%	66.5	65.1	63.8	71.7
Those having plan	32.7	33.5	34.9	36.2	28.3
	100.0%	100.0	100.0	100.0	100.0
Wage earner only	51.7%	56.8	49.2	47.2	54.4
Entire family	45.8	40.4	49.1	50.9	42.2
Wage earner and wife or husband	1.3	2.0	.3	1.5	1.8
Miscellaneous	1.2	.8	1.4	.4	1.6

AGE—MEMBERS RECEIVING CARE

2. Which member or members of this family have received medical or hospital care under the plan?

	Total	*20-29*	*30-39*	*40-49*	*50-Up*
Those having plan	(32.7%)	(33.5)	(34.9)	(36.2)	(28.3)
	100.0%	100.0	100.0	100.0	100.0
None	57.0%	61.1	59.8	56.3	52.1
Received care	43.0	38.9	40.2	43.7	47.9
	100.0%	100.0	100.0	100.0	100.0
Wage earner	56.7%	60.0	49.6	50.9	64.2
Other members of family	26.3	27.4	30.4	26.3	22.5
Both	17.0	12.6	20.0	22.8	13.3

AGE—SATISFACTORY SERVICE

3. (IF TREATMENT OR CARE RECEIVED, ASK) Was the service, care or treatment entirely satisfactory?

	Total	*20-29*	*30-39*	*40-49*	*50-Up*
Those who have received care	(43.0%)	(38.9)	(40.2)	(43.7)	(47.9)
	100.0%	100.0	100.0	100.0	100.0
Yes	92.5%	91.6	93.0	94.9	90.5
No	6.5	7.4	6.1	5.1	7.4
Don't know	1.0	1.0	.9	----	2.1

AGE—ADDITIONAL PAYMENTS MADE

4. Did you have to pay the doctor or hospital anything extra?

	Total	*20-29*	*30-39*	*40-49*	*50-Up*
Those who have received care	(43.0%)	(38.9)	(40.2)	(43.7)	(47.9)
	100.0%	100.0	100.0	100.0	100.0
Yes	48.7%	50.0	53.9	44.1	46.0
No	48.2	47.8	43.5	52.5	50.0
Don't know	3.1	2.1	2.6	3.4	4.0

AGE—FAIRNESS OF ADDITIONAL CHARGE

5. (IF HAD TO PAY EXTRA) Was the extra charge fair?

	Total	*20-29*	*30-39*	*40-49*	*50-Up*
Those paying extra charge	(48.7%)	(50.0)	(53.9)	(44.1)	(46.0)
	100.0%	100.0	100.0	100.0	100.0
Yes	81.3%	84.8	80.7	75.0	83.6
No	13.9	13.0	12.9	19.2	10.5
Don't know	4.8	2.2	6.4	5.8	5.9

AGE—ATTITUDE TOWARD COMPULSORY MEMBERSHIP

6. Do you think that subscription to or membership in a medical or hospital plan should be compulsory or voluntary?

	Total	*20-29*	*30-39*	*40-49*	*50-Up*
Interviews	100.0%	100.0	100.0	100.0	100.0
Voluntary	76.0%	80.2	75.7	73.3	75.5
Compulsory	21.7	17.9	22.9	24.2	21.7
Don't know	2.1	1.9	1.4	2.3	2.7
Do not believe in it	.1	----	----	.1	----
Refused to state	.1	----	----	.1	.1

AGE—OPINION ON STATE-OPERATED PLAN

7. There are now available several different types of medical and hospital plans. Do you think the State of California should promote and operate a plan in competition to those in existence?

	Total	*20-29*	*30-39*	*40-49*	*50-Up*
Interviews	100.0%	100.0	100.0	100.0	100.0
Yes	50.2%	54.5	51.4	49.2	47.0
No	25.8	22.4	26.6	25.6	27.6
Don't know	24.0	23.1	22.0	25.2	25.4

AGE—ATTITUDE TOWARD COMPULSORY MEMBERSHIP IN STATE PLAN

8. (IF COMPULSORY ANSWERED TO QUESTION No. 6) Should people be compelled to belong to or subscribe to the State Plan or should they be allowed to take their choice?

	Total	*20-29*	*30-39*	*40-49*	*50-Up*
Those who believe in compulsory membership	(21.7%)	(17.9)	(22.9)	(24.2)	(21.7)
	100.0%	100.0	100.0	100.0	100.0
Allowed to take choice	56.9%	59.0	60.2	56.4	53.6
Should be compelled to belong	42.9	41.0	39.2	43.0	46.4
Don't know	.1	----	----	.6	----
Refused to state	.1	----	.6	----	----

AGE—FINANCIAL SOURCES FOR STATE PLAN

9. If the State should start such a plan, how should it be paid for?

	Total	*20-29*	*30-39*	*40-49*	*50-Up*
Interviews	*100.0%	*100.0	*100.0	*100.0	*100.0
Payroll tax	34.8%	39.6	36.3	33.3	31.2
Sales tax	28.9	25.0	29.3	29.0	32.3
Property tax	6.7	7.6	5.7	5.8	7.4
Other	24.4	23.2	24.5	26.7	23.7
Don't know	5.6	5.5	5.2	4.7	6.7
Refused to state	.1	----	----	----	.1
Miscellaneous	2.5	.8	2.0	2.8	1.9

* Totals to more than 100% because of multiple answers.

AGE—ELIGIBILITY OF VARIOUS TYPES OF HEALERS

10. If a State plan should be adopted, would it include treatment by Osteopaths, Chiropractors, Other, Drugless healers, All, None?

	Total	*20-29*	*30-39*	*40-49*	*50-Up*
None	26.5%	29.7	27.3	25.5	24.6
Those who would include	73.5	70.3	72.7	74.5	75.4
	*100.0%	*100.0	*100.0	*100.0	*100.0
All	70.7%	67.9	70.8	67.8	74.3
Osteopaths	19.9	21.3	20.5	21.8	17.5
Chiropractors	17.1	16.4	18.1	18.3	16.1
Drugless healers	1.1	.8	.7	1.3	1.4
Dentists	.4	.6	----	.7	.4
Other	6.5	7.8	7.5	6.3	5.1
Against it	.1	----	----	----	.1
Don't know	2.5	3.9	2.2	2.7	1.5

* Totals to more than 100% because of multiple answers.

OCCUPATION—DISTRIBUTION OF SAMPLE

All persons interviewed must *first* be qualified to be in one of the following classifications.

	Total	*Owner-Mgr. Official*	*Profes-sional*	*Clerical Sales*	*Wage Earner Shop*	*Domestic Service*	*House-wife*	*Farmer*	*Farm Worker*
Interviews		(15.9)	(10.3)	(18.2)	(26.8)	(3.4)	(20.5)	(2.9)	(2.0)
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Wage earner	68.2%	87.7	87.3	82.3	83.9	81.2	7.2	72.3	78.0
Wife of wage earner	30.8	11.5	12.2	16.1	15.0	16.2	92.6	26.7	22.0
Husband of wage earner	.5	.4	.3	.8	.4	1.7	----	----	----
Wage earner and wife of wage earner	.5	.4	.2	.8	.7	.9	.2	1.0	----

OCCUPATION—SUBSCRIBERS TO MEDICAL PLAN

1. Who, living in this household, subscribes, belongs to, or is taken care of under any medical or hospital group or insurance plan?

	Total	*Owner-Mgr. Official*	*Profes-sional*	*Clerical Sales*	*Wage Earner Shop*	*Domestic Service*	*House-wife*	*Farmer*	*Farm Worker*
None	67.3%	74.8	64.9	64.9	62.5	76.9	67.6	69.3	86.8
Those having plan	32.7	25.2	35.1	35.1	37.5	23.1	32.4	30.7	13.2
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Wage earner only	51.7%	42.8	46.0	57.3	58.8	40.7	47.4	35.5	55.6
Entire family	45.8	55.8	50.0	38.6	39.5	59.3	50.0	64.5	44.4
Wage earner and wife or husband	1.3	1.4	.8	1.4	.6	----	2.2	----	----
Miscellaneous	1.2	----	3.2	2.7	1.1	----	.4	----	----

OCCUPATION—MEMBERS RECEIVING CARE

2. Which member or members of this family have received medical or hospital care under the plan?

	Total	Owner-Mgr. Official	Profes-sional	Clerical Sales	Wage Earner Shop	Domestic Service	House-wife	Farmer	Farm Worker
Those having plan	(32.7%)	(25.2)	(35.1)	(35.1)	(37.5)	(23.1)	(32.4)	(30.7)	(13.2)
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
None	57.0%	49.3	48.0	57.3	59.1	63.0	59.2	58.1	100.0
Received care	43.0	50.7	52.0	42.7	40.9	37.0	40.8	41.9	----
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Wage earner	56.7%	----	56.3	58.5	64.3	70.0	53.8	46.2	----
Other members of family	26.3	----	20.3	29.8	23.6	10.0	30.1	30.8	----
Both	17.0	----	23.4	11.7	12.1	20.0	16.1	23.0	----

OCCUPATION—SATISFACTORY SERVICE

3. (IF TREATMENT OR CARE RECEIVED, ASK (Was the service, care treatment entirely satisfactory?

	Total	Owner-Mgr. Official	Profes-sional	Clerical Sales	Wage Earner Shop	Domestic Service	House-wife	Farmer	Farm Worker
Those who have received care	(43.0%)	(50.7)	(52.0)	(42.7)	(40.9)	(37.0)	(40.8)	(41.9)	
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Yes	92.5%	97.0	90.7	92.5	91.4	100.0	92.5	84.6	----
No	6.5	3.0	9.3	4.3	7.9	----	6.5	15.4	----
Don't know	1.0	----	----	3.2	.7	----	1.0	----	----

OCCUPATION—ADDITIONAL PAYMENTS MADE

4. Did you have to pay the doctor or hospital anything extra?

	Total	Owner-Mgr. Official	Profes-sional	Clerical Sales	Wage Earner Shop	Domestic Service	House-wife	Farmer	Farm Worker
Those who have received care	(43.0%)	(50.7)	(52.0)	(42.7)	(40.9)	(37.0)	(40.8)	(41.9)	
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Yes	48.7%	66.2	54.0	46.2	38.6	30.0	50.5	53.8	----
No	48.2	30.9	44.4	52.7	56.4	70.0	46.2	38.5	----
Don't know	3.1	2.9	1.6	1.1	5.0	----	3.3	7.7	----

OCCUPATION—FAIRNESS OF ADDITIONAL CHARGE

5. (IF HAD TO PAY EXTRA) Was the extra charge fair?

	Total	Owner-Mgr. Official	Profes-sional	Clerical Sales	Wage Earner Shop	Domestic Service	House-wife	Farmer	Farm Worker
Those paying extra charge	(48.7%)	(66.2)	(54.0)	(46.2)	(38.6)	(30.0)	(50.5)	(53.8)	
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Yes	81.3%	88.9	82.3	85.7	74.5	100.0	74.4	85.7	----
No	13.9	8.9	14.7	7.2	15.7	----	23.4	14.3	----
Don't know	4.8	2.2	3.0	7.1	9.8	----	2.2	----	----

OCCUPATION—ATTITUDE TOWARD COMPULSORY MEMBERSHIP

6. Do you think that subscription to or membership in a medical or hospital plan should be compulsory or voluntary?

	Total	Owner-Mgr. Official	Professional	Clerical Sales	Wage Earner Shop	Domestic Service	Housewife	Farmer	Farm Worker
Interviews	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Voluntary	76.0%	76.2	80.7	73.1	74.9	78.5	79.8	63.0	64.2
Compulsory	21.7	21.4	17.6	24.3	22.2	19.8	18.5	37.0	34.3
Don't know	2.1	2.0	1.7	2.4	2.9	1.7	1.7	----	----
Do not believe in it	.1	.2	----	----	----	----	----	----	----
Refused to state	.1	.2	----	.2	----	----	----	----	1.5

OCCUPATION—OPINION ON STATE-OPERATED PLAN

7. There are now available several different types of medical and hospital plans. Do you think the State of California should promote and operate a plant in competition to those in existence?

	Total	Owner-Mgr. Official	Professional	Clerical Sales	Wage Earner Shop	Domestic Service	Housewife	Farmer	Farm Worker
Interviews	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Yes	50.2%	46.9	47.4	49.6	55.1	54.4	45.6	58.0	52.3
No	25.8	31.9	34.0	27.5	23.7	17.5	20.9	23.0	18.5
Don't know	24.0	21.2	18.6	22.9	21.2	28.1	33.5	19.0	29.2

OCCUPATION—ATTITUDE TOWARD COMPULSORY MEMBERSHIP IN STATE PLAN

8. (IF COMPULSORY ANSWERED TO QUESTION No. 6) Should people be compelled to belong to or subscribe to the State Plan or should they be allowed to take their choice?

	Total	*Owner-Mgr. Official*	*Professional*	*Clerical Sales*	*Wage Earner Shop*	*Domestic Service*	*Housewife*	*Farmer*	*Farm Worker*
Those who believe in compulsory membership	(21.7%)	(21.4)	(17.6)	(24.3)	(22.2)	(19.8)	(18.5)	(37.0)	(34.3)
	100.0%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Allowed to take choice	56.9%	50.9	60.0	59.9	58.0	56.5	68.3	29.7	31.8
Should be compelled to belong	42.9	48.2	40.0	40.1	42.0	43.5	31.7	70.3	63.6
Don't know	.1	.9	----	----	----	----	----	----	----
Refused to state	.1	----	----	----	----	----	----	----	4.6

OCCUPATION—FINANCIAL SOURCES FOR STATE PLAN

9. If the State should start such a plan, how should it be paid for?

	Total	*Owner-Mgr. Official*	*Professional*	*Clerical Sales*	*Wage Earner Shop*	*Domestic Service*	*Housewife*	*Farmer*	*Farm Worker*
Interviews	*100.0%	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0
Payroll tax	34.8%	33.3	33.9	36.4	37.2	29.8	35.1	26.0	25.8
Sales tax	28.9	29.4	25.5	25.3	31.2	41.2	26.3	41.0	36.4
Property tax	6.7	7.3	6.7	6.1	5.8	9.6	5.9	9.0	18.2
Other	24.4	25.2	27.5	26.7	21.7	16.7	26.2	20.0	21.2
Don't know	5.6	5.0	6.4	6.1	4.4	3.5	7.8	4.0	1.5
Refused to state	.1	----	----	----	----	----	.1	----	----
Miscellaneous	2.5	2.6	2.3	2.1	2.1	2.6	.6	2.0	----

* Totals to more than 100% because of multiple answers.

OCCUPATION—FINANCIAL SOURCES FOR STATE PLAN

10. If a State plan should be adopted, should it include treatment by Osteopaths, Chiropractors, Other, Drugless healers, All, None?

	Total	*Owner-Mgr. Official*	*Profes-sional*	*Clerical Sales*	*Wage Earner Shop*	*Domestic Service*	*House-wife*	*Farmer*	*Farm Worker*
None	26.5%	26.9	24.3	30.1	23.7	23.3	28.2	26.7	25.4
Those who would include	73.5	73.1	75.7	69.9	76.3	76.7	71.8	73.3	74.6
	*100.0%	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0	*100.0
All	70.7%	70.5	71.0	70.5	72.6	74.2	66.7	74.3	76.0
Osteopaths	19.9	21.4	23.4	18.5	19.0	18.0	20.8	16.2	18.0
Chiropractors	17.1	17.9	13.6	15.1	17.6	14.6	19.0	23.0	20.0
Drugless healers	1.1	1.3	.4	1.1	1.0	3.4	1.0	----	2.0
Dentists	.4	.3	.8	.5	.1	----	.6	1.4	----
Other	6.5	4.3	7.5	10.3	3.7	6.7	7.5	1.4	----
Against it	.1	.3	----	----	----	----	----	----	----
Don't know	2.5	3.3	1.5	2.7	2.1	2.2	3.2	----	----

* Totals to more than 100% because of multiple answers.

UNION MEMBERSHIP—DISTRIBUTION OF SAMPLE

All persons interviewed must *first* be qualified to be in one of the following classifications:

	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
		(24.7)	(16.4)	(3.9)	(4.4)	(.1)	(75.2)
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Wage earner	68.2%	73.9%	75.9%	79.4%	61.2%	------	66.5%
Wife of wage earner	30.8	25.4	23.3	20.6	37.4	------	32.5
Husband of wage earner	.5	.2	------	------	1.4	------	.5
Wage earner and wife of wage earner	.5	.5	.8	------	------	------	.5

UNION MEMBERSHIP—SUBSCRIBERS TO MEDICAL PLAN

1. Who, living in this household, subscribes, belongs to, or is taken care of under any medical or hospital group or insurance plan?

	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
None	67.3%	59.6	58.6	61.8	61.2	------	69.6
Those having plan	32.7	40.4	41.4	38.2	38.8	------	30.4
	100.0%	100.0	100.0	100.0	100.0	------	100.0
Wage earner only	51.7	58.1	56.5	64.0	59.6	------	48.6
Entire family	45.8	39.8	40.4	36.0	40.4	------	48.8
Wage earner and wife or husband	1.3	1.5	2.2	------	------	------	1.1
Miscellaneous	1.2	.6	.9	------	------	------	1.5

UNION MEMBERSHIP—MEMBERS RECEIVING CARE

2. Which member or members of this family have received medical or hospital care under the plan?

	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
Those having plan	(32.7%)	(40.4)	(41.4)	(38.2)	(38.8)	------	(30.4)
	100.0%	100.0	100.0	100.0	100.0	------	100.0
None	57.0	61.0	62.0	50.0	66.7	------	55.2
Received care	43.0	39.0	38.0	50.0	33.3	------	44.8
	100.0%	100.0	100.0	100.0	100.0	------	100.0
Wage earner	56.7%	64.1	70.2	52.0	52.6	------	54.9
Other members of family	26.3	23.4	23.8	28.0	15.8	------	27.3
Both	17.0	12.5	6.0	20.0	31.6	------	17.8

UNION MEMBERSHIP—SATISFACTORY SERVICE

3. (IF TREATMENT OR CARE RECEIVED, ASK) Was the service, care or treatment entirely satisfactory?

	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
Those who have received care	(43.0%)	(39.0)	(38.0)	(50.0)	(33.3)	------	(44.8)
	100.0%	100.0	100.0	100.0	100.0	------	100.0
Yes	92.5%	95.3	94.0	96.0	100.0	------	91.6
No	6.5	4.7	6.0	4.0	------	------	6.9
Don't know	1.0	------	------	------	------	------	1.5

UNION MEMBERSHIP—ADDITIONAL PAYMENTS MADE

4. Did you have to pay the doctor or hospital anything extra?

	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
Those who have received care	(43.0%)	(39.0)	(38.0)	(50.0)	(33.3)	------	(44.8)
	100.0%	100.0	100.0	100.0	100.0	------	100.0
Yes	48.7%	42.2	41.2	50.0	36.8	------	50.9
No	48.2	51.6	52.9	41.7	57.9	------	47.0
Don't know	3.1	6.2	5.9	8.3	5.3	------	2.1

UNION MEMBERSHIP—FAIRNESS OF ADDITIONAL CHARGE

5. (IF HAD TO PAY EXTRA) Was the extra charge fair?

	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
Those paying extra charge	(48.7)	(42.2)	(41.2)	(50.0)	(36.8)	------	(50.9)
	100.0%	100.0	100.0	100.0	------	------	100.0
Yes	81.3%	72.6	65.6	75.0	100.0	------	83.5
No	13.9	15.7	25.0	------	------	------	13.5
Don't know	4.8	11.7	9.4	25.0	------	------	3.0

UNION MEMBERSHIP—ATTITUDE TOWARD COMPULSORY MEMBERSHIP

6. Do you think that subscription to or membership in a medical or hospital plan should be compulsory or voluntary?

	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
Interviews	100.0%	100.0	100.0	100.0	100.0	------	100.0
Voluntary	76.0%	72.2	70.5	74.8	76.2	------	76.9
Compulsory	21.7	26.6	28.4	23.7	22.4	------	20.4
Don't know	2.1	1.2	1.1	1.5	1.4	------	2.5
Do not believe in it	.1	------	------	------	------	------	.1
Refused to state	.1	------	------	------	------	------	.1

UNION MEMBERSHIP—OPINION ON STATE-OPERATED PLAN

7. There are now available several different types of medical and hospital plans. Do you think the State of California should promote and operate a plan in competition to those in existence?

	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
Interviews	100.0%	100.0	100.0	100.0	100.0	------	100.0
Yes	50.2%	58.8	58.0	62.6	58.5	------	47.8
No	25.8	21.1	21.7	22.1	18.4	------	27.1
Don't know	24.0	20.1	20.3	15.3	23.1	------	25.1

UNION MEMBERSHIP—ATTITUDE TOWARD COMPULSORY MEMBERSHIP IN STATE PLAN

8. (IF COMPULSORY ANSWERED TO QUESTION No. 6) Should people be compelled to belong to or subscribe to the State Plan or should they be allowed to take their choice?

	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
Those who believe in compulsory membership	(21.7%)	(26.6)	(28.4)	(23.7)	(22.4)	------	(20.4)
	100.0%	100.0	100.0	100.0	100.0	------	100.0
Allowed to take choice	56.9%	54.7	57.0	35.5	60.6	------	57.3
Should be compelled to belong	42.9	45.3	43.0	64.5	39.4	------	42.3
Don't know	.1	-----	------	------	------	------	.2
Refused to state	.1	-----	------	------	------	------	.2

UNION MEMBERSHIP—FINANCIAL SOURCES FOR STATE PLAN

9. If the State should start such a plan, how should it be paid for?

	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
Interviews	*100.0%	*100.0	*100.0	*100.0	*100.0	------	*100.0
Pay roll tax	34.8%	39.5	40.3	42.5	35.6	------	33.2
Sales tax	28.9	27.4	29.4	20.5	27.4	------	29.8
Property tax	6.7	7.3	6.8	8.7	8.2	------	6.5
Other	24.4	22.8	21.5	31.5	21.9	------	24.9
Don't know	5.6	4.0	4.1	1.6	5.5	------	6.1
Refused to state	.1	-----	------	------	------	------	.1
Miscellaneous	2.5	2.4	2.4	1.6	3.4	------	1.7

* Totals to more than 100% because of multiple answers.

UNION MEMBERSHIP—ELIGIBILITY OF VARIOUS TYPES OF HEALERS

10. If a State plan should be adopted, should it include treatment by Osteopaths, Chiropractors, Other, Drugless healers, All, None?

	Overall	*Union*	*A. F. L.*	*C. I. O.*	*Other Unions*	*Refused to State*	*Non-Union*
None	26.5%	24.2	23.1	22.7	29.9	------	27.7
Those who would include	73.5	75.8	76.9	77.3	70.1	------	72.3
	*100.0%	*100.0	*100.0	*100.0	*100.0	------	*100.0
All	70.7%	71.6	71.6	78.8	67.0	------	70.3
Osteopaths	19.9	20.3	20.9	16.2	23.3	------	20.1
Chiropractors	17.1	18.2	20.8	13.1	15.6	------	16.6
Drugless healers	1.1	1.0	1.0	1.0	1.0	------	1.1
Dentists	.4	.2	------	------	1.0	------	.5
Other	6.5	5.5	4.9	6.1	8.7	------	6.9
Against it	.1	-----	------	------	------	------	.1
Don't know	2.5	2.1	2.2	------	3.9	------	2.7

* Totals to more than 100% because of multiple answers.

INSTRUCTIONS TO INTERVIEWERS

By *KNIGHT AND PARKER*

(All Persons Interviewed Must First Be Qualified to Be in One of the Following Classifications)

Wage Earner___ Wife of Wage Earner___ Husband of Wage Eearner___

1. Who, living in this household, subscribes, belongs to, or is taken care of under any medical or hospital group or insurance plans?

   Wage earner only___ Entire family___ None___

Ask Questions 2 Through 5 Only of Those Covered

2. Which member or members of this family have received medical or hospital care under the plan?

   Wage earner___ Other members of family___ Both___ None___

3. (IF TREATMENT OR CARE RECEIVED, ASK) Was the service, care or treatment entirely satisfactory?

   Yes___ No___ DK___

4. Did you have to pay the doctor or hospital anything extra?

   Yes___ No___ DK___

5. (IF YES) Was the extra charge fair?

   Yes___ No___ DK___

6. Do you think that subscription to or membership in a medical or hospital plan should be compulsory or voluntary?

   Compulsory___ Voluntary___

7. There are now available several different types of medical and hospital plans. Do you think the State of California should promote and operate a plan in competition to those in existence?

   Yes___ No___ DK___

8. (IF COMPULSORY TO QUESTION 6) Should people be compelled to belong to or subscribe to the State Plan___ or should they be allowed to take their choice ___?

9. If the State should start such a plan, how should it be paid for?

   Payroll tax___ Sales tax___ Property tax___ Other___

10. If a State plan should be adopted, should it include treatment by Osteopaths___, Chiropractors___, Other___, Drugless healers___, All___, None___?

How many in the family including the wage earner and the dependents? _____

Sex: Male___ Female___

Age: 20-29___ 30-39___ 40-49___ 50-up___

Property Owner___ No____

Union: C.I.O.___ A.F.L.___ Other___ Non-Union___

Occupation:

Owner-Mgr. Official _____ Wage Earner Shop_____

Professional _____ Domestic Service _____

Clerical Sales _____ Housewife _____

Farmer _____

Farm Workers _____

Urban___ Rural___

Area _____ Address _____

Your Name _____

SECTION NINE

RECOMMENDATIONS

MATERNAL AND CHILD WELFARE

The State Department of Public Health now being engaged in a survey of Hospital and Medical Facilities existing or needed in this State it is recommended that suitable legislation be introduced whereby the State Department of Public Health shall amplify its report to include an estimate of those particular facilities needed to provide adequate Maternity Care, for the Women of California and Pediatric Services up to the second year of life for children born in this State to the end that in this most crucial time in the medical history of women and children proper care shall be the right of all.

ACTUARIAL RECORDS

It is recommended that suitable legislation be introduced providing that full actuarial records be kept in the administration of the recently enacted Unemployment Compensation Disability Benefits Act and that a full time actuary be employed to make quarterly and yearly actuarial reports to the Governor and to the Legislature in order that the incidence of disease, accidents and illnesses among those in subject employment may be more accurately studied.

UNIFORM REPORTING AND CONTINUING STUDIES OF HEALTH CARE PROBLEM

Under the existing voluntary plans providing insurance against the costs of medical care and hospitalization a wealth of statistical information may be obtained through a uniform procedure in the payment of claims and recording of policy holders.

The studies of this committee have indicated that patterns of incidence or morbidity as among classifications of policy holders or in areas are tending to become established.

When complete records are kept it is evident that departures from normal expectancies will indicate better or poorer health or limitation or liberalization of benefits, all of which are and should be the concern of the Legislature.

It is therefore recommended that suitable legislation be introduced providing, first, that the Insurance Commissioner require all Voluntary and Commercial Insurance Plans, profit or nonprofit, providing Medical and/or Hospital Benefits to make quarterly reports to the State Department of Public Health and, secondly that the State Department of Public Health publish the actuarial and medical data obtained from such reports in order that the Medical Profession and the Insurance Carriers may have the benefit of studies to be made concerning the health of the people as reflected by all possible means of obtaining information.

It is further recommended that such legislation provide that the State Department of Public Health after the publication of such bulletins and studies sponsor Health Conferences which shall be attended by representatives of the Medical Societies, the Insurance Companies and members of proper Legislative Committees.

Such conferences shall have no power to legislate but may, by resolution, call upon the Legislature for the introduction of any laws or regulations deemed to be necessary or desirable for the health of the people.

CONTINUATION OF COMMITTEE AND SUPPLEMENTAL REPORT

This report has stated, and the committee finds, that the problem remains of providing medical care for those who can not financially afford the needed protection.

Since the Legislature has adopted the Unemployment Disability Benefits Act (effective, as to benefits payable, May 21, 1947) and since this committee has recommended above that the State Department of Public Health report on legislation needed to provide adequate Maternity Care for the women of California and Pediatric Services up to the second year of life for children born in this State we have a starting point from which further study may be made leading to provision for Prepaid Medical Care.

This committee, therefore, recommends that at the beginning of the fifty-seventh session of the Legislature, or at any intervening extraordinary session of the fifty-sixth session, the Assembly Health Care Investigating Committee be reconstituted and authorized to file a report and, in continuing its investigations, to hold hearings during the Constitutional Recess at which various interested parties be given an opportunity to criticize or add to the report herein filed.

By this means this committee acknowledges that the present report is not the final work on this important subject. But we are now in a position to base further studies on the work already covered and explore other channels which may be presented.

SECTION TEN

BIBLIOGRAPHY

(1)—Outline of presentation and exhibits in support of A.B. 449. (The Peoples Health Act) by California C.I.O. Council Research Dept. March 2, 1945.

(2)—Medical Care for the American People, Final Report of the Committee on the Costs of Medical Care.

(3)—Health Insurance for California, Report of the Social Security and Manpower, and Research Department, California State Chamber of Commerce.

(4)—State Relief Administration Study of 1935.

(5)—Medical Care and Costs in California Families in Relation to Economic Status, 1937. (Margaret C. Klem)

(6)—Incidence of Illness and the Receipt and Cost of Medical Care among Representative Family Groups, 1933. (Klem, Falk, Sinai)

(7)—Report of the Senate Committee to Investigate the High Cost of Medical Care, 1935.

TEXT OF H. R. 295

As printed on pp. 118, 119 of Assembly Journal for June 16, 1945 and adopted in the Assembly the same day.

RELATIVE TO THE CREATION OF THE ASSEMBLY HEALTH CARE INVESTIGATING INTERIM COMMITTEE

WHEREAS, The health of the people of the State of California is a matter of continuing concern to the Legislature; and

WHEREAS, There has been presented at this Fifty-sixth Regular Session of the Legislature numerous measures relating to making the health, medical, hospital and other care of the people of the State, including the raising of revenues to provide such care, a function of the State Government; and

WHEREAS, The Legislature is in need of further information as to the need for the care to be provided, the types of care to be provided, the classes of persons for whom the care should be provided, the administration of the care, the cost of the care, and the existing and possible sources of revenue which may be used to provide the care; now, therefore, be it

Resolved by the Assembly of the State of California, as follows:

1. The Assembly Health Care Investigating Interim Committee is hereby created and appointed and authorized and directed to ascertain study and analyze all facts relating to the health of the people of the State of California, the adequacy of existing sources to maintain and improve the health of the people, any additional means for maintaining and improving the health of the people, the need for the provision of health care for the people, or any classes thereof, by the State Government or any agency thereof, the cost of providing for health care by the State Government or any agency thereof, and the existing and possible sources of revenue which may be used to provide such care, including but not limited to the operation, effect, administration, enforcement and needed revision of any and all laws in any way bearing upon or relating to the subject of this resolution, and to report thereon to the Assembly at any regular or special session, including in the reports its recommendations for appropriate legislation.

2. The committee shall consist of seven Members of the Assembly appointed by the Speaker thereof. The chairman shall be selected, and vacancies occurring or existing in the membership of the committee shall be filled, by the Speaker.

3. The committee is authorized to act during this session of the Legislature, including any recess, and after final adjournment until the commencement of the next regular session, with authority to file its final report not later than the first day of July, 1946.

4. The committee and its members shall have and exercise all of the rights, duties and powers conferred upon Investigating Committees and their members by the provisions of the Joint Rules of the Senate and Assembly and of the Standing Rules of the Assembly as they are adopted and amended from time to time, which provisions are incorporated herein and made applicable to this committee and its members.

5. The committee has the following additional powers and duties:

(a) To cooperate with and secure the cooperation of county, city, city and county, and other local law enforcement agencies in investigating any matter within the scope of this resolution and to direct the sheriff of any county to serve subpenas, orders and other process issued by the committee.

(b) To report its findings and recommendations to the Legislature, to the Governor, and to the people from time to time, not later than the first day of July, 1946.

(c) To do any and all other things necessary or convenient to enable it fully and adequately to exercise its powers, perform its duties, and accomplish the objects and purposes of this resolution.

(d) To meet at the State Capitol, or at any other place within this State or within the United States.

6. The sum of fifty thousand dollars ($50,000) or so much thereof as may be necessary is hereby made available from the Contingent Fund of the Assembly for the expenses of the committee and its members and for any charges, expenses or claims it may incur under this resolution, to be paid from the said Contingent Fund of the Assembly and disbursed, after certification by the chairman of the committee, upon warrants drawn by the State Controller upon the State Treasurer.

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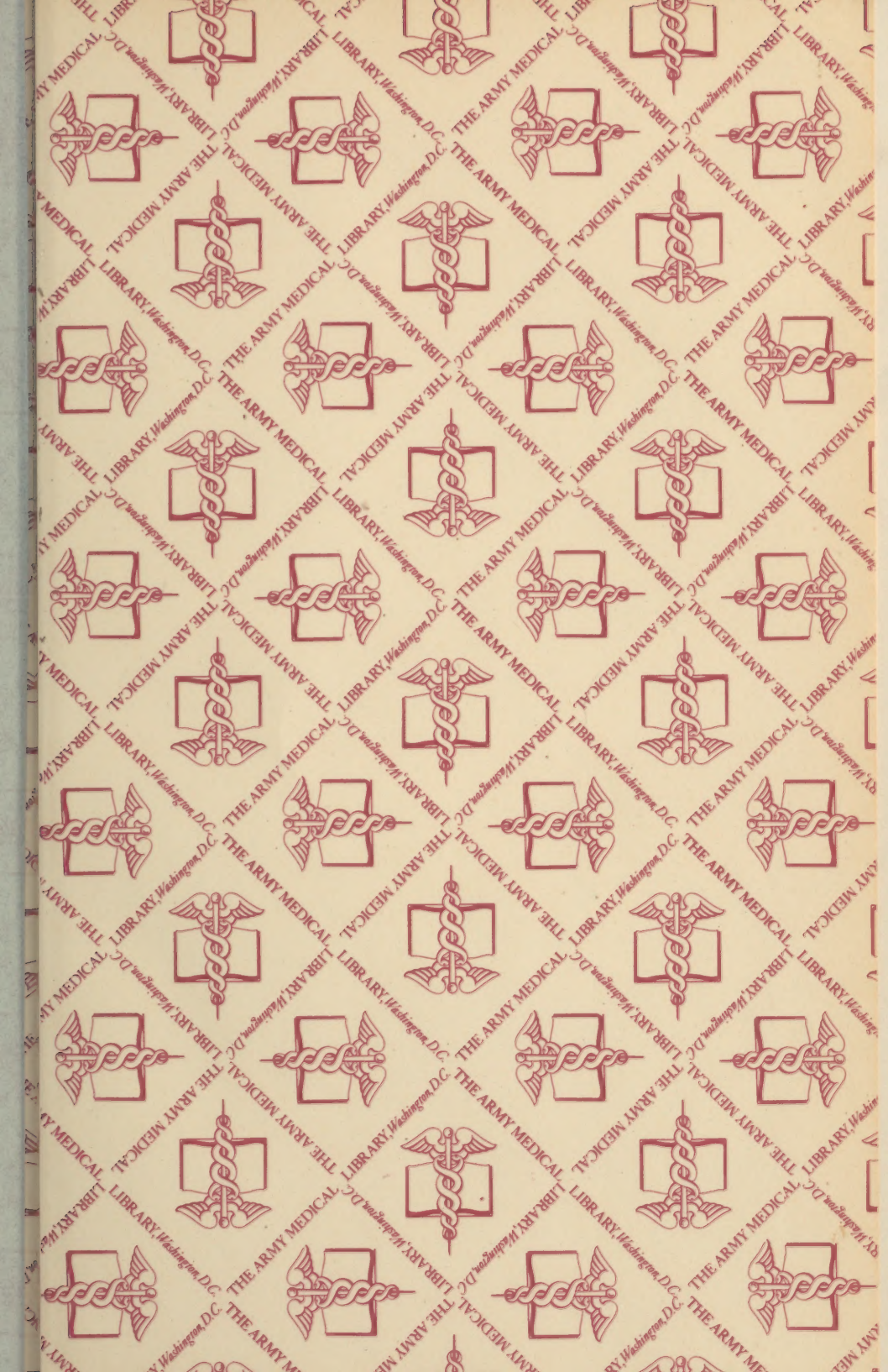
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